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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Rwanda

The Executive Director recommends that the Executive Board approve the country programme of Rwanda for the period 1993-1997 in the amount of $9,900,000 from general resources, subject to the availability of funds, and $13 million in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

THE SITUATION OF CHILDREN AND WOMEN

1. Rwanda is a country with limited economic potential, a high population growth rate (4.8 per cent per year) and one of the smallest land areas in Africa. In 1991, the population rose to 7.3 million, an increase of 50 per cent over a 10-year period, with an average population density of 271 persons per square kilometre. The average size of family farms and the fertility of the soil are on the decline. There are few opportunities for off-farm employment. In 1989, large parts of the southern portion of the country suffered from famine. Mere survival is becoming increasingly difficult.

2. Almost one out of five children weighs less than 2.5 kilograms at birth. Twenty per cent of children do not live to see their fifth birthday. About 50,000 children under one year of age die every year, 135 every day. These deaths are the result of the cumulative and synergistic effects of frequent infections and chronic malnutrition. The most common diseases directly responsible for child malnutrition and death are malaria, acute respiratory infections (ARI) and diarrhoea. More than 50 per cent of five-year-old children suffer from stunting; and 6 per cent of children under three years of age suffer from severe and 25 per cent from moderate malnutrition. Intestinal parasites and micronutrient deficiencies, including deficiencies in vitamin A, iron and iodine, are widespread. Water consumption is about 10 litres per person per day in rural areas. Only 40 per cent of households have safe latrines that are easy to use. Twenty per cent of mothers use oral rehydration therapy (ORT) at home. Eighty per cent of women practise exclusive breast-feeding for the first six months of a child's life. Weaning foods and practices are often inappropriate.

3. Most women are subsistence farmers. These women and their children survive on food they grow on their husbands' small farms, supplemented by meagre non-farm incomes. The average woman bears more than eight children and spends between 15 and 20 years of her life pregnant or breast-feeding. The contraceptive prevalence rate was estimated at 12.6 per cent in 1991. More than 80 per cent of pregnant women undergo two antenatal visits, but women do not reduce their workload during pregnancy and breast-feeding. Average weight-gain during pregnancy is about 2 kilograms. At-risk pregnancies account for up to 30 per cent of all those seen in health centres. No reliable figures are available, but the maternal mortality rate (MMR) is thought to be about 300 per 100,000 live births.

4. Only an estimated 40 per cent of women are literate. The high number of early school leavers hinders attempts to increase the literacy rate. Enrolment is roughly equal for boys and girls during the first three years of primary school, but the drop-out rate for girls begins to climb from the age of 12 years onwards as girls assume greater household and child-care responsibilities.

5. In 1991, more than 1 million children attended primary school, 49.8 per cent of whom were girls. Three out of four children start primary school at the age of seven years, but only one third of them complete primary education. The student/teacher ratio is more than 90:1 in the first three

years of primary school. Forty-five per cent of primary school teachers are unqualified. Many schools lack desks and blackboards, and parents are too poor to pay the increasing costs of education. Primary school is free and compulsory, but many families find it difficult to meet the indirect costs of education: uniforms; reading and writing materials; and the costs in terms of the loss of children's work in fetching wood and water, carrying out essential agricultural tasks and, in the case of girls, looking after younger siblings.

6. Most Rwandans live within five kilometres of a health centre, but because of the hilly terrain, almost one half of them have to walk more than one hour to reach it. The quality of service is low owing to the lack of qualified staff; the difficulty of providing a reliable flow of essential drugs; poor training, motivation and supervision of staff; and the lack of community participation in the management of health problems and services. At health centres, the integration of maternal and child health (MCH), family planning and nutrition services and the standardization of diagnosis and treatment are major challenges. The health information system generates useful reports, but these have not been of assistance to communities in taking responsibility for their own health.

7. High fertility rates, heavy workloads and declining incomes put the survival and development of women under increasing stress. Women work long hours to grow food and to fetch wood and water, as well as to feed, care for and educate their children. They cannot legally own land, benefit little from improved farming inputs and have limited access to a few years of basic education. They control neither the number of children they have nor household income and assets. It is remarkable that four out of five children survive to the age of five years. However, current conditions do little to enhance the situation and status of women, who face increasing impoverishment and marginalization.

8. Since 1983, the acquired immune deficiency syndrome (AIDS) epidemic in urban areas has become a cause of increasing concern. At the end of 1991, between 150,000 and 220,000 people were thought to be living with the AIDS virus. Human immunodeficiency virus (HIV) prevalence rates among women attending antenatal clinics were 26.7 per cent in urban areas and 3.3 per cent in rural areas. In 1991, between 7,000 and 10,000 babies were estimated to have been born HIV-positive. There are more than 6,000 AIDS orphans in Kigali. HIV-positive rates are three times higher among women than among men between the ages of 15 and 19 years old.

9. Per capita gross national product was estimated at $260 in 1991. Since 1987, the fall in the world price of coffee has caused an economic crisis. Coffee accounted for 84 per cent of exports in 1986, but revenues fell by 40 per cent between 1987 and 1991. External and internal debt repayments account for almost 30 per cent of State revenues.

10. Rwanda is in transition to a multi-party democracy despite sporadic ethnic violence. Since October 1990, armed incursions by exiles operating along the northern frontier have destabilized the country. The defence budget quadrupled between 1989 and 1991 and now accounts for more than 30 per cent of the national budget. A cease-fire has been holding since July 1992.

11. A structural adjustment programme will run until the end of 1993. It aims to liberalize the economy, cut subsidies to coffee producers and freeze salaries and recruitment. Between 1990 and 1992, national expenditure on health and education fell from 25 to 17 per cent. With 20 per cent inflation, social expenditure per inhabitant is falling by more than 10 per cent per year. External budgetary support and food aid are likely to remain necessary. The survival and development of children and women depend not only on increased efficiency and relevance of basic services, but also on the transition to a more participatory society and peace.

PROGRAMME COOPERATION, 1988-1992

12. The 1988-1992 country programme, which included four sectoral programmes, aimed at contributing to the reduction of the infant mortality rate (IMR) and the under-five mortality rate (U5MR) and enhancing the well-being of children and women.

Health and nutrition

13. Health and nutrition accounted for 40 per cent of expenditures and consisted of six projects: expanded programme on immunization (EPI); MCH; control of diarrhoeal diseases (CDD); nutrition; essential drugs/Bamako Initiative; and AIDS prevention.

Expanded programme on immunization

14. Rwanda was among the first countries to reach universal child immunization (UCI) in 1989 and has since maintained coverage for all antigens at more than 80 per cent. Vaccination is available at all 286 health centres. A February 1992 national coverage survey found the following coverage for children under one year of age: anti-tuberculosis vaccine, 94 per cent; polio vaccine and three doses of combined diphtheria/pertussis/tetanus vaccine, 85 per cent; and two doses of tetanus toxoid (TT2), 88 per cent. Measles no longer features on the list of the 10 leading childhood diseases. Reported cases of poliomyelitis have declined to the point where eradication may be possible by 1995. Political commitment, logistics and social mobilization were essential for the achievement of UCI. Many agencies took part in the effort. UNICEF provided all vaccines except for polio, and strengthened the cold chain and logistics throughout the health system. More than 600 health workers underwent training. The project has made a significant impact on targeted diseases and has strengthened capacity in planning, implementation and monitoring.

Essential drugs/Bamako Initiative

15. The Ministry of Health launched a Bamako Initiative project in 1989. The pilot phase aimed to test the feasibility of cost recovery at the community level. The initial response was high and 97 health centres are now using the scheme. The project is strengthening community participation in and management of health services through training, monitoring and regular supervision.

AIDS prevention

16. In 1988, studies of knowledge, attitudes and practices about AIDS provided the basis for education and training in AIDS prevention among in-school and out-of-school youth. The project introduced AIDS messages in school curricula, textbooks and teaching materials. More than 5,000 primary and secondary school heads and teachers underwent training. A 1991 evaluation showed that students had increased their understanding of AIDS transmission and changed their attitudes towards AIDS victims, but behavioural change was more difficult to assure. The evaluation suggested decentralized decision-making and a less formal approach for out-of-school youth. The project provides training and support for youth leaders chosen by their peers in six pilot sectors. It encourages group discussions and social and sporting activities. The aim is to develop group awareness and solidarity among vulnerable unemployed youth, especially girls.

Other health and nutrition projects

17. To institutionalize weighing during pregnancy, UNICEF gave adult weighing scales to all health centres and helped in the design of a health and nutrition card for mothers. More than 1,700 traditional midwives received training and delivery kits, but follow-up was difficult. More than 80 per cent of women undergo two prenatal consultations and receive TT2, but most mothers call on midwives only after problems have developed during childbirth. A national strategy for MCH, incorporating health, family planning and nutrition, came into effect in 1991.

18. In 1992, the "baby-friendly" hospital initiative began in the two leading hospitals by producing posters, promoting the "Ten steps to successful breast-feeding" and training a team of trainers. A study at Kigali Hospital Centre found that HIV transmission was possible if the mother became HIV-positive while she was breast-feeding. In an area where infectious diseases cause most child deaths, this does not justify a reduction in the promotion of breast-feeding, except when mothers are confirmed as HIV-positive. In such cases, the mother will be advised of the risks, given the choice whether to breast-feed or not, and provided with medical supervision for alternatives to breast-feeding.

19. Dehydration caused by diarrhoea remains a major cause of child mortality. The main strategies for CDD are to prevent diarrhoea and improve case management. Since 1988, oral rehydration sachets have been available at all health centres and more than 7,000 health workers have undergone ORT training. The area of CDD has lacked leadership and a coherent plan of action. Senior health workers lack ORT training. The mid-term review pointed to the need to stress breast-feeding, feeding during episodes of diarrhoea and the integration of diarrhoea control and nutrition.

20. Traditionally, nutrition activities have been curative. Since 1988, UNICEF has supported the integration of nutrition and growth monitoring to transform the old vaccination cards into child health cards. While supporting training in therapeutic nutrition, the project also funded studies on weaning practices, household food consumption budgets and malnutrition. Growth monitoring and promotion activities were introduced among pregnant women and

vulnerable children in two prefectures. In 1991, the Ministry of Agriculture agreed to include nutrition and household food security in questionnaires to monitor nutritional status, food practices and coping mechanisms among 2,500 sample households throughout the country. The project supported the iodization of salt and vitamin A and iron supplementation through health worker training and supplies. Artificial distinctions between health and nutrition persist, with health workers needing time and guidance on how to integrate the promotion of good nutrition into hectic schedules.

Water supply and sanitation

21. The water supply and sanitation programme for 1988-1992 aimed to improve the quality of water and reduce water-related diseases in rural areas. A national inventory located and listed more than 25,000 water sources. Of these, 1,700 sources were protected, and washing slabs were constructed at 1,100 of the protected sources. Eleven gravity-fed water supply systems were completed, serving 55,000 people, and 146 water technicians were trained. To improve the availability of water in the household, 50 water storage tanks made of ferro-cement or bamboo-cement were built. Through the hygiene and sanitation project, 45 school latrine blocks and 250 family latrines were constructed. Posters and pamphlets for hygiene education were also produced and distributed. Pilot activities included the installation of manual pumps on springs and hand-dug wells. UNICEF also intervened to provide water, jerrycans and latrines for war-displaced people. At present, the programme is in need of more qualified personnel. Sector planning, monitoring and maintenance also require strengthening. Many women are treasurers of water management committees, but on the whole, their representation remains low. Community contributions accounted for 20 per cent of construction costs, but have decreased during the transition to multi-party democracy. The mid-term review stressed management and maintenance, and the need to link water supply with sanitation, CDD and household food security.

Household food security

22. The programme aimed at increasing commitment to household food security and nutrition; improving the availability, processing and storage of food in the household; and increasing the income and reducing the workload of women. Activities included loan guarantee and revolving credit funds for women for small and micro-enterprises, for which the repayment rate is more than 95 per cent. The project supported 40 training sessions for female entrepreneurs and 100 workshops for non-governmental organizations (NGOs) supporting women's groups. It also provided training support for 50 women's groups and cooperatives for the improvement of food distribution, storage and marketing. Start-up has been slow, but the project has succeeded in creating acceptance of the need for credit to women entrepreneurs.

Literacy and education

23. To promote basic education and literacy, the programme offered support for improving the quality and quantity of teachers. Primary school curricula were adapted to rural life and more than 400 teacher trainers were retrained. Studies and surveys brought education statistics up to date. Training was offered to 180 play-school teachers, and literacy instructors and supervisors

were trained to serve in more than 1,300 literacy centres. Fifty rural communities were served by teaching materials, vehicles and social mobilization activities. The lack of supplementary funding prevented services to the remainder of the 145 communes. However, only 15 per cent of the more than 300,000 literacy students passed the literacy test. The programme suffered from the conceptual weaknesses of a mass literacy campaign based on top-down mobilization ill adapted to the circumstances and needs of the beneficiaries. A 1992 review concluded that increased access to primary education is the best strategy for promoting basic skills and knowledge and reducing illiteracy. The review recommended the improvement of the learning environment, the provision of learning materials to reduce school drop-out and repeater rates and a strategy of focused, functional literacy promotion, emphasizing literacy for those who need it. The review also recommended a greater focus on operational research and a coordinated effort in the education sector in support of the follow-up to the World Conference on Education for All (WCEFA).

Lessons learned

24. The programme succeeded in reaching and maintaining UCI, starting Bamako Initiative activities in one third of health centres, reintroducing nutrition as a major concern and strengthening support to women's groups. In the area of education, weaknesses remain.

25. The experience gained from the current programme cycle showed that studies and evaluations made an important contribution to the social mobilization process. The evaluations have shown that the programme strategy should be more flexible to respond to the continuing emergency situation. Another important lesson was that the monitoring and evaluation system needs to be strengthened so that cost-efficiency and programme impact can be measured. The major priorities now are to introduce an emphasis on the learning process and to strengthen programme integration and community participation, especially by women.

Country programme preparation process

26. Training for all staff took place with the Burundi office in June 1991. In November 1991, work began on the situation analysis and the Ministry of Planning formed a programming team. The exercise took 10 months, with constant headquarters and regional office support. After an orientation workshop for government counterparts in January 1992, the Regional Director, the Chief of the Bamako Initiative Management Unit and programme staff from the region and headquarters took part in the strategy meeting in mid-February. The workshop analysed problems at household, community and central government levels and identified major areas for programme intervention. A March 1992 in-house retreat refined the country programme structure. The preparation of the programme plan of operations began in April, with six teams of government, NGO and UNICEF programme staff holding meetings over a period of one month. This process led to a programming retreat in May 1992. In mid-July, the preview meeting included an in-house revision of programme documents, and a one-day formal preview, chaired by the Director of Planning and involving more than 60 government and NGO representatives. The UNICEF office completed programme and budget documents by September 1992.

RECOMMENDED PROGRAMME COOPERATION, 1993-1997

Recommended general resources: $9,900,000
Supplementary funding: $13,000,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Primary health care	3 465	5 200	8 665
Basic education	1 980	1 950	3 930
Water supply and sanitation	1 485	4 550	6 035
Household food and income security	1 485	1 300	2 785
Information, organization-building and advocacy	1 485	-	1 485
Total	9 900	13 000	22 900

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Major national goals

27. The President of the Republic of Rwanda attended the World Summit for Children (WSC) and signed its Declaration and Plan of Action. The Ministry of Planning has completed a national programme of action (NPA) and has set up a national commission for Summit follow-up, which includes multisectoral representation from members of the United Nations system, the diplomatic corps, NGOs, the media and different ministries. The NPA includes the seven major WSC goals, with additional goals for family planning and the control of AIDS. The NPA aims at almost complete vaccination coverage by the year 2000 and the elimination of neonatal tetanus and the eradication of indigenous polio by 1995. The 1993-1997 programme of cooperation aims to advance the following national goals and objectives, reflected in the NPA for children.

MAJOR NATIONAL PROGRAMME OF ACTION GOALS FOR RWANDA

		1990	1997	2000
1.	IMR (per 1,000 live births)	117	105	90
	U5MR (per 1,000 live births)	198	170	150
2.	MMR (per 100,000 births)	300	255	200
3.	Malnutrition			
	- severe (% under 5 years)	7	6	5
	- moderate (% under 5 years)	23	19	17
4.	Water			
	- % access to safe drinking water	65	75	80
5.	Sanitation			
	- % access to sanitary means of excreta disposal	41	60	70
6.	Net school enrolment rate			
	- % age 7 to 14 years old	62	70	80
7.	Female adult literacy rate			
	- % of population over 15 years old	37	50	60
8.	Contraceptive prevalence rate			
	- % child-bearing couples	12.6	30	48
9.	HIV prevalence in population 15 to 19 years old	(No data available)		

Country programme goal and objectives

28. The programme goal is to reinforce the country's capacity to increase the chances of survival and to enhance the development potential of its children and women. There are four major programme objectives for the end of 1997: (a) to reduce U5MR from the 1990 NPA baseline indicator of 198 per 1,000 live births to 170 per 1,000 live births, an estimated reduction of 10 per cent; (b) to reduce MMR from 300 to 255 per 100,000 births, an estimated reduction of 15 per cent; (c) to reduce chronic malnutrition among children under five years of age from 30 to 25 per cent, an estimated reduction of 20 per cent; and (d) to reduce the socio-economic vulnerability of the poorest households.

29. The causes of the high IMR, MMR and malnutrition rates and of the socio-economic vulnerability of many households are complex and interactive. The structure of the new country programme will allow each sectoral programme to contribute to the achievement of the following intersectoral objectives: (a) to reduce the mortality rate attributable to malaria among children under five years of age from 90 to 70 per 1,000 live births; (b) to reduce the mortality rate attributable to ARI among children under five years of age from 40 to 30 per 1,000; (c) to reduce the mortality rate attributable to diarrhoeal

diseases among children under five years of age from 22 to 18 per 1,000; (d) to reduce the percentage of children who lose weight during weaning by one third; (e) to increase the percentage of women who gain at least 5 kilograms during pregnancy by half; and (f) to increase the proportion of women with an interval of 24 months between two deliveries by 50 per cent.

30. The country programme will consist of five programme sectors and 11 projects. By placing a set of specific, quantified, cross-cutting objectives high in the hierarchy of objectives, the programme takes into account the synergistic impact of activities in different sectors. This formalizes the intersectoral nature of activities, encourages integration and reduces duplication. At the sectoral programme level, objectives are qualitative in recognition that activities within each programme will work synergistically towards measurable outcomes at a higher level and across the whole country programme. Projects within the programmes have quantified output objectives that should be easy to evaluate using a desk-top review of programme documentation, including regular reports and programme field visits.

Programme strategy

31. The programme strategy is based on the Bamako Initiative, WCEFA, the Convention on the Rights of the Child and WSC, as adapted to the national context. The programme will promote simple as well as complex but achievable measures such as vaccination, ORT, breast-feeding, hand-washing with soap, spring protection, functional literacy and the empowerment of women's groups. Individuals, households and groups will be assisted to acquire basic knowledge and skills by improving the access to and use of information. In the transition to a decentralized, pluralistic system, the programme will promote dialogue between basic service providers and the population. This will call for a change in approach by community workers and the strengthening of structures for community participation, along with attention to greater relevance and accountability. Priority will be given to women and girls. Each project will increase and reinforce women's participation in decision-making. Each sectoral programme has a training component which will build national, regional and local capacity. The programme will collaborate with church groups and NGOs working at the commune level. In the current context of military and political instability, climatic fluctuations and structural food deficits, UNICEF will take measures to help the country prepare for and respond to emergencies. Strengthening and accelerating child survival measures in the country programme are seen as essential elements of this response.

32. The major programme thrusts are the maintenance of UCI, the control of infectious diseases, the strengthening of basic education, the protection of the coming generation against HIV infection and the improvement of resource management in vulnerable households. The sectoral programme components will stress decentralization and collaboration among different services, the convergence of activities and services, the improvement of the quality and accountability of services, the promotion of equity of access to services and community participation. Projects will build synergy around major high-impact programme areas by integrating interventions in water supply, literacy and household food security around health centres implementing the Bamako Initiative and in 20 communes that will serve as demonstration areas.

Primary health care

33. The programme will strengthen the capacity of the health system to provide a set of essential services according to the principles of the Bamako Initiative and to reduce the incidence of those diseases that contribute the most to mortality. Specific objectives are to reduce the incidence of measles from 80 to 40 per 100,000 population by the end of 1997; to eliminate neonatal tetanus and eradicate poliomyelitis by the end of 1995; to reduce the proportion of women suffering from anaemia from 50 to 30 per cent; to reduce the rate of iodine deficiency disorders to less than 10 per cent; and the rate of vitamin A deficiency to less than 0.5 per cent of children under five years of age. The programme covers the whole country and will target 1.5 million children under five years of age and 460,000 pregnant women. The programme consists of two projects:

(a) The health system management project will strengthen the planning, organization, coordination, monitoring and evaluation of primary health care (PHC) activities at national and regional levels. The project will promote the rational management and use of resources at health centres, and standard diagnosis and treatment of common ailments. A structure for efficient essential drugs supply management will be established and a contribution will be made to the initial stock of drugs. Community participation in health services will be strengthened through support to health centre management committees, with increased female representation. The project includes social mobilization and operational research;

(b) The MCH project will provide a minimum package of integrated essential services at all health centres. These include EPI, growth monitoring and nutrition promotion; malaria, the control of ARI and CDD; safe motherhood and family planning; and control and prevention of sexually transmitted diseases and AIDS. The project aims to increase quality and coverage by training, supervision, monitoring and social mobilization.

Basic education

34. The programme aims to improve basic survival and development knowledge and skills, especially among women and girls. Specific objectives are to increase the percentage of children between the ages of 7 and 14 years attending primary school from 62 to 70 per cent and to reduce the drop-out rate for girls at the end of the third year of primary school from 14 to 8 per cent. The programme will also increase the literacy rate for women and girls from 37 to 50 per cent. An AIDS prevention project in the education sector will reduce the rate of HIV prevalence and the percentage of HIV-positive women in the 15- to 19-year-old-age group. The protection and community care of children in difficult circumstances because of AIDS will be improved. The programme consists of three projects:

(a) The formal education project will assist in setting up a national commission to follow up on WCEFA and support the retraining of unqualified primary schoolteachers; the revision of curricula in line with the TURWANE KU BUZIMAR, the Rwandan version of Facts for Life; and the strengthening of the supervision system. Prototype teaching materials will be developed and

produced, and a revolving fund will be set up to help students gain access to reading and writing materials;

(b) The non-formal education project will focus on promoting functional literacy among women's groups in the catchment areas of Bamako Initiative health centres, making optimal use of Facts for Life. Activities include the training of literacy instructors and regular monitoring and supervision;

(c) The AIDS prevention project will support teacher training for AIDS prevention in all primary schools and out-of-school activities to motivate students against AIDS. For out-of-school children, the project will extend focus group approaches to all communes, which will involve awareness creation activities, the production and dissemination of educational messages as indicated in Facts for Life, the formation and support of groups, the training of group leaders and supervision. The AIDS prevention project is national in scope and will benefit an estimated 1.5 million young people, more than 800,000 of whom are women and girls.

Water supply and sanitation

35. The programme aims to increase the availability of safe water supplies and to improve environmental hygiene in the household. It also aims to reduce the time spent by women and children collecting water and firewood, while protecting the environment by preventing damage of the sources. Rural access to safe water will be increased from 65 to 75 per cent and the average amount of water used will be increased from 10 to 20 litres per person per day. The distance between the water source and the home will be reduced. In demonstration areas around health centres, the programme will increase access to safe latrines from 41 to 60 per cent and cut the cost of family latrines by half. The programme includes two projects:

(a) The water supply project will improve and protect 1,500 spring catchments with small water storage tanks and laundry slabs. Gravity-fed water supply systems will also be constructed, with distribution systems totalling 200 kilometres and 1,200 household water storage tanks in iron- or bamboo-cement. Hand-pumps will be installed on drilled boreholes and improved wells on a pilot groundwater potential. Other activities will include support for a water sector coordination committee and the introduction of the water supply and sanitation monitoring system. Each water point will have a management committee with at least one woman member. Masons, water technicians and pump attendants will be trained; techniques for filtering water in the household will be tested; and seedlings will be provided for the protection of sources. In addition, rapid response to emergencies will be ensured;

(b) The hygiene and sanitation project will support the construction of 500 public ventilated improved latrine blocks at health centres, schools and other suitable places. The project will set up production sites for reinforced latrine slabs and train 800 community workers in hygiene promotion. Education messages on safe hygiene and sanitation practices will be developed and disseminated. The project will benefit a population of 950,000, mainly women and children, who are responsible for 80 per cent of the work associated with water supply construction and the collection of water for household use.

Household food and income security

36. The programme aims to improve the management, control and creation of resources in the household to better meet basic needs. Women's access to credit, agricultural inputs and training will be increased. The main objectives are intersectoral: reductions in chronic and acute malnutrition and the incidence of low birth weight and weight loss during weaning; and increases in weight gain during pregnancy. The programme will focus on children under three years of age and pregnant and lactating women. It will target low-income women, female heads of household and households with less than 0.5 hectares of land in 20 demonstration communes. The programme consists of two projects:

(a) The household revenue and resource management project will provide training for members of women's groups, agricultural extension agents and community workers in agricultural and animal husbandry techniques, the use of improved seeds and fertilizers and micro-enterprise development. Credit and savings schemes for women's groups and households with little access to land will also be supported. The project will distribute seedlings for growing trees, promote improved stoves to reduce the consumption of firewood and encourage early child care development by supporting community-based systems for crêches and safe child care;

(b) The food security and feeding practices project will improve weaning practices and promote exclusive breast-feeding. A "baby-friendly" initiative will promote breast-feeding support groups and education and mobilization on the special needs of children and pregnant and lactating women. Community-based growth promotion, nutritional surveillance in famine-prone areas, improved and enriched weaning foods and improved food preservation and storage will also be supported.

Information, organization-building and advocacy

37. The programme aims to stimulate dialogue and action at all levels of decision-making to solve the priority problems of children and women. It also aims to sensitize decision makers to the needs of children and women through advocacy for the implementation of the NPA. In addition to national advocacy coverage, the programme will operate in 20 communes, with an estimated population of about 1 million, where it will test and replicate the community-based information and organization project. There will be 26 sentinel sites, with a sample of 4,000 households and a population of 20,000 people. The programme consists of two projects:

(a) Community-based information and organization-building, which will empower the population to take responsibility for solving local problems by strengthening the capacity of community members to assess and analyse priorities and to take action through community organization. The project will stress beneficiary participation in planning and managing services provided by projects in PHC, basic education, water supply and sanitation, and household food and income security programmes, as well as participation in social mobilization activities based on Facts for Life. The discussion of information collected in the community on problems affecting children and women will be central to the learning process of the project. Community-based information systems will use sentinel sites to monitor the conditions of children and

women. The discussion and analysis of results by service providers and community representatives will improve the relevance, efficiency and accountability of services. The project will provide technical support to community organizations and project management committees. Activities include community surveys, the training of committee members and community workers, monitoring and evaluation, and operational research;

(b) The advocacy project will sensitize decision makers to the importance of implementing policies and increasing budgets for activities that benefit children and women. The project includes support for a WSC national follow-up unit. Regular consultation meetings will be sponsored at the national level to discuss progress towards the Summit goals and the results of community surveys. The mass media will receive technical support. Communication materials will be provided on topics relevant to World Summit follow-up.

Monitoring and evaluation

38. The information, organization-building and advocacy programme will link NPA goal monitoring, communication, research and country programme monitoring and evaluation. The programme will use the human, financial and organizational resources of the line ministries implementing other sectoral programmes to carry out measurement and assessment activities once every three or four months. Community workers and members of project committees will carry out surveys to get recent information and maintain an up-to-date "rolling" situation analysis covering NPA goals and quantitative and qualitative information on programme impact, as well as the impact of the lessons learned by the recipients of Facts for Life, coverage and cost. Advocacy efforts will benefit from the feedback of survey results from the household to the national level. UNICEF will train people from communities and from different levels of the service delivery system in monitoring. At each sentinel site, committees and community groups will select research priorities, choose the methodologies, participate in field work and analyse and feedback results. The programme will stress greater understanding of beneficiary perceptions of problems. Annual programme reviews, a mid-term review in 1995 and an external evaluation in 1996 will be carried out.

Coordination with other agencies

39. The programme will build on the cooperation with other agencies that developed during the programme preparation exercise. The programming cycles of the United Nations Development Programme, the United Nations Population Fund (UNFPA) and UNICEF have been synchronized to strengthen the synergistic effect of United Nations interventions. Each agency will contribute to the reduction of poverty through a coherent response to the growing gap between usable land and population. The World Health Organization (WHO), UNFPA and UNICEF will focus on contributions in health, education, family planning and food and income security at the household level. Collaboration between WHO and UNICEF will remain crucial to success. In a situation of vulnerability to famine, collaboration between the World Food Programme and UNICEF will strengthen the existing coordinated response to emergencies. Donor agency coordination is a major issue. UNICEF already collaborates with many agencies in PHC, water supply and sanitation and education, including the United States Agency for International Development, Rotary International, and bilateral agencies from

France, Belgium and Germany in PHC and the World Bank and UNDP for the national programme of social action under structural adjustment. Collaboration with NGOs and church groups will be strengthened in line with the trend towards decentralization.

Programme management

40. The management objectives for the 1993-1997 country programme are: to allow for the adequate staffing of new programme activities in community-based information systems and monitoring the goals for the 1990s; to provide staff to implement commitments to Education for All and AIDS prevention; and to strengthen office capacity in information resource management and secretarial and clerical support. While the heads of four sectoral programmes will report to the programme officer, the information, organization-building and advocacy programme will be run by national Professionals reporting to the representative. The revised 1992-1993 budget proposes the establishment of one international Professional post in basic education, two national Professional posts in basic education and household food and income security and three secretarial/clerical posts. The proposed 1994-1995 budget includes the establishment of one national Professional post in information/communication and programme assistant posts in health and water supply, one secretarial and one ancillary post.

41. Although the economic and financial situation of the country and the Government are in a poor state and the central administration is weak, the strategy proposed for the new programme is expected to attract donor support. In fact, the new programme will concentrate at the peripheral level, where work will continue with community involvement and the support of local administration, regardless of changes that may occur at the centre. A more realistic amount of supplementary funds, $5.4 million less than the amount approved by the Executive Board in 1988 (E/ICEF/1988/P/L.5), is now proposed.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Rwanda	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	189	(1991)	Very high U5MR
Infant mortality rate	112	(1991)	Very high IMR
GNP per capita	$ 260	(1991)	Low GNP
Total population	7.3 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	198	271	369	382
Infant deaths (under 1)	(Thousands)	28	35	42	43
Under-five deaths	(Thousands)	48	59	70	71
Under-five mortality rate (per 1,000 live births)		242	219	191	189
Infant mortality rate (under 1) (per 1,000 live births)		143	129	113	112

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1976/1982-1983)	Moderate & severe	28	33 a/
	Severe	6	4 a/
Babies with low birth weight (%, 1971/1990)		17	17
% of primary school children reaching final grade, 1980/1988)		47	36

NUTRITION INDICATORS	About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1985)	94 /85/ 74	97* / 97* / 74*
Prevalence of wasting (%, 1976/1982-1991)	11	1 a/
Prevalence of stunting (%, 1982-1983)	..	34 a/
Daily per capita calorie supply (% of requirements, 1988-1990)	..	82
Food production per capita index (Index 1979-1981=100, 1980/1991)	98	86
Household expenditure (% of total income, 1980-1985)	All food/cereals	30 / 11

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1987)			24
Access to health services	Total	..	27
(% of population, 1980)	Urban/rural	.. / ..	60 / 25
Access to safe water	Total	55	50
(% of population, 1980/1985)	Urban/rural	48 / 55	79 / 48
Access to adequate sanitation	Total	51	57
(% of population, 1980/1985)	Urban/rural	60 / 50	77 / 55
Births attended by trained personnel (%, 1979/1989)		25	22
Maternal mortality rate (per 100,000 live births, 1982)		..	210

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	51	83	92	94
	DPT	17	50	84	85
	Polio	15	56	83	85
	Measles	42	52	83	81
Pregnant women (%) immunized against:	Tetanus	5	21	87	88

TABLE 1 (continued)

Rwanda

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	63 / 59	69 / 65
(%, 1980/1989)	Male	66 / 61	69 / 65
	Female	60 / 57	68 / 65
Secondary enrolment ratio (gross/net)	Total	3 / 2	7 / 7
(%, 1980/1989)	Male	4 / 2	9 / 8
	Female	3 / 1	6 / 6
Adult literacy rate, 15 years & older	Total	32	50
(%, 1970/1990)	Male/female	43 / 21	64 / 37
Radio/television sets (per 1,000 population, 1980/1990)		29 / ..	62 / ..

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	3728	5163	7027	7271	9766
Population aged 0-15 years	(Thousands)	1862	2665	3629	3772	5085
Population aged 0-4 years	(Thousands)	748	1049	1441	1497	1933
Urban population (% of total)		3.2	4.8	5.6	5.7	6.8
Life expectancy at birth	Total	44	46	47	47	47
(years)	Male	43	44	45	45	45
	Female	46	47	48	48	48
Total fertility rate		8.1	8.5	8.5	8.4	7.4
Crude birth rate (per 1,000 population)		53	53	52	52	48
Crude death rate (per 1,000 population)		21	20	18	18	17

		About 1980	Most recent
Contraceptive prevalence rate (%, 1983)		..	10
Population annual growth rate	Total	3.3	3.1
(%, 1965-1980/1980-1991)	Urban	6.3	4.8

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1991)		1.6	-2.6
Inflation rate (%, 1965-1980/1980-1990)		12	4
Population in absolute poverty (%, 1977)	Urban/rural	30 / 90	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure	Health/education	5 / 19	5*/ 26*
(% of total expenditure, 1980/1987)	Defence	13	..
Household expenditure (% of total income, 1980-1985)	Health/education	3 / 4	.. / ..
Official development assistance:	$US millions	155	328
(1980/1991)	As % of GNP	13	17
Debt service (% of goods and services exports, 1980/1990)		2	11

a/ Indicates data that differ from the standard definition or refer to only part of a country.
* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988–1992 a/

COUNTRY: RWANDA
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $7,921,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSP	GR	FSP	GR	FSP	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	1971	1229	695	436	424	561	1164	943	4254	3163	3169	10643	7423	13806
Household food security and nutrition	118	24	104	161	455		568	130	1245	899	315	1994	1560	2893
Water supply and sanitation	218	643	67	53	521	124	255	756	1061	1449	1576	3835	2637	5284
Education	616	23	457	4	159		592		1824	1490	27	1971	1851	3461
Advacacy, planning and programme support	185		53		295		528	3	1061	920	3		1064	920
Emergency	85								85	84			85	84
Freight	152	10							152		10		162	
GRAND TOTAL	3345	1929	1376	654	1854	685	3107	1832	9682 b/	8005 c/	5100	18443 d/	14782	26448

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Including expenditure from global funds allocation and additional general resources for unfunded supplementary funding programme for health and household food security.

c/ Including $84,000 allocations from the Emergency Reserve Fund.

d/ Of this amount, $8,500,000 remains unfunded.

.../

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: RWANDA Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	693	693	693	693	693	3465
	FSF	160	32				192
	NSF	1040	1040	1040	1040	1040	5200
Household food security and nutrition	GR	297	297	297	297	297	1485
	FSF	200					200
	NSF	260	260	260	260	260	1300
Water supply and sanitation	GR	297	297	297	297	297	1485
	FSF	57					57
	NSF	910	910	910	910	910	4550
Basic education	GR	396	396	396	396	396	1980
	FSF	20					20
	NSF	390	390	390	390	390	1950
Social mobilization and advocacy	GR	297	297	297	297	297	1485
TOTAL	GR	1980	1980	1980	1980	1980	9900 a/
	FSF	437	32				469
	NSF	2600	2600	2600	2600	2600	13000
GRAND TOTAL		5017	4612	4580	4580	4580	23369

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.

a/ Excluding $465,000 balances of additional general resources allocation for unfunded supplementary funding programmes in the previous cycle.

TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

RWANDA

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1993–1997 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS a/ (In thousands of US dollars)		
	GR	FSP	NSP	TOTAL	D2/L7	D1/L6	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES										d/							
Health	3465			3465				1			1	1	1	3	645	143	788
Household food security and nutrition	1485			1485				1			1		1	2	645	39	684
Water supply and sanitation	1485			1485				1			1			1	645		645
Basic education	1980			1980				1		1	2		1	3	795	39	834
Information, organization and advocacy	1485			1485								1	1	2		143	143
Programme support e/													5	5		192	192
TOTAL GR	9900			9900				4		1	5	2	9	16	2730	556	3286
SUPPLEMENTARY FUNDING																	
Health		192	5200	5392								2	2	4		282	282
Household food security and nutrition		200	1300	1500								1	2	3		183	183
Water supply and sanitation		57	4550	4607								1	2	3		183	183
Basic education		20	1950	1970								1		1		104	104
TOTAL SF		469	13000	13469								5	6	11		752	752
TOTAL GR & SF				23369				4		1	5	7	15	27	2730	1308	4038
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994–1995)	Operating costs			888													
	Staffing b/						1	1	1		3	2	5	10	794	197	991
GRAND TOTAL (GR + SF + ADM)							1	5	1	1	8	9	20	37			
	Number of posts and staff costs:																
	– At the beginning of previous programme (1988)										6	1	9	16	N/A	N/A	N/A
	– At the beginning of proposed programme (1993)										d/ 8	9	20	37	N/A	N/A	N/A
	– At the end of proposed programme (1997) (Indicative only)										9	10	20	39	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

d/ Includes 1 UNV.

e/ Spread over various sectors.

Abbreviations: GR = general resources; FSP = funded supplementary funding; NSP = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service. ADM = administrative.

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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1993 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Central African Republic

The Executive Director recommends that the Executive Board approve a commitment of $6 million from general resources, subject to the availability of funds, and a commitment of $12.5 million from supplementary funding, subject to the availability of specific-purpose contributions, for the country programme of the Central African Republic for the period 1993-1997.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1992/P/L.3 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. The Central African Republic has a population of 3.1 million inhabitants, of whom 43 per cent are children under the age of 15 and nearly 18 per cent are children under the age of 5. The population is primarily rural, and 80 per cent of the country's inhabitants reside in rural areas. Near half the urban population is concentrated in Bangui, the national capital. The gross national product of approximately $390 per capita ranks it among the middle-income African countries. Though certainly poorer than Cameroon, Gabon or the Congo, the Central African Republic has great economic potential in the area of hydrological power, owing to its position on the continent, its plentiful rainfall and its many rivers. The subsoil is rich in mineral resources that have scarcely begun to be tapped.

2. Since the time that the current cooperation programme was drawn up, on the basis of studies made in 1988, the economic situation in the Central African Republic has continued to deteriorate rapidly, weakening the capacity for action, reducing the national budget and diminishing the quality of life, especially for women and children. Lower national revenues and administrative problems have affected the level of basic services and set off a process of impoverishment in the Central African Republic. In the last 18 months, the political opposition has mounted a series of strikes and demonstrations; in most cases, these were due to salary arrears in the public sector, in turn caused by a decrease in foreign assistance and a poor performance in the recovery of debts.

3. The infant mortality rate (IMR) stands at 106 per 1,000 live births and the under-five mortality rate (U5MR) is 180 per 1,000 live births; the maternal mortality rate (MMR) is estimated at 600 per 100,000 live births. Owing to the expanded programme of immunization (EPI), the incidence of such diseases as whooping cough and measles has substantially dropped. At present the chief causes of infant and maternal mortality are parasitic infestations (19 per cent), diarrhoeal diseases (18 per cent), malaria (15 per cent), acute respiratory infections (ARI) (10 per cent) and sexually transmitted diseases (STD), whose exact impact is still difficult to assess. This is particularly so for acquired immune deficiency syndrome (AIDS), which has an incidence of 8 per cent; children under age five account for 25 per cent of the infected population.

4. Parasitic infections and malaria are a serious problem for both mothers and their children; gynaecological and obstetrical infections, as well as numerous, frequent, and unmonitored pregnancies, are also common. Malaria, especially when combined with nutritional deficiencies, is often the cause of low birth weight, and according to a national survey that took place in 1991, 62 per cent of the population from 8 to 18 years of age suffers from iodine deficiency.

5. According to the available data, malnutrition from advanced protein-calorie deficiency affects approximately 7.5 per cent of children from

birth through age five. Yet, 25 per cent of the same population group suffers from chronic malnutrition and other deficiencies. The chronic malnutrition springs from many factors, but especially from premature weaning, low household income, and a lack of nutritional knowledge, which often reflects poverty, unemployment, and the mother's lack of education. Acute malnutrition seems to predominate in the outskirts of large urban centres, where the quality of life has noticeably declined during the last 10 years owing to rapid urbanization and the lack of social services.

6. Access to health-care facilities and services remains limited, because only 45 per cent of the population lives within 5 kilometres of the nearest health-care facility, and because the medical care provided is of inferior quality owing to equipment and personnel shortages and, often, a total absence of medicine. Furthermore, although there is one public or private health unit for approximately every 6,500 people, there are considerable regional disparities. Nearly 30 per cent of personnel and health-care services are concentrated in the capital, where only 15 per cent of the population lives. Resources allocated for the health sector dropped steadily from 1988 to 1991, from 6.3 per cent of the national budget in 1988 to 4.2 per cent in 1990. External aid, though considerable, falls short of the country's needs. As for water supply and sanitation, although surface water is abundant, less than 20 per cent of the population in rural and suburban areas has clean drinking water. Water-borne diseases and the lack of sanitation continue to be major concerns, especially for the health of women and children.

7. The state of education, in particular pre-school and basic education, is of extreme concern and was exacerbated by over eight months of teachers' strikes in 1991. For several years, owing to the implementation of structural adjustment programmes, not only has the school enrolment rate been falling, but the quality of instruction has been declining sharply.

8. According to a recent study on the enrolment of girls, conducted jointly by UNICEF and the United Nations Educational, Scientific and Cultural Organization (UNESCO), the disparity in attendance rates between boys and girls (only 38 per cent of the students enrolled in basic education are girls) is significant, and stems from social and cultural factors deeply rooted in ancestral tradition. Over the last three years, State allocations for education have dropped from 25 per cent to 19 per cent of the national budget. In the context of the structural economic crisis, an increase in the volume of resources allocated for the social sector, although called for by the World Conference on Education for All and the World Summit for Children, will be difficult to achieve even if it is in keeping with official policy. In rural areas, the situation is indeed alarming: 99 per cent of women under the age of 25, and 86 per cent of women between the ages of 15 and 24 have not yet completed the middle level of Basic I. Since women - as producers, mothers and educators - are the principal agents in the development of a nation, their literacy is essential.

9. The lack of services and facilities to meet the needs of those who have migrated to the city or the suburbs from the rural areas has not only broken up the traditional extended family but has also removed the nuclear family unit from its original social group, and often from all social control. Furthermore, unemployment, lack of income, and highly unstable social and economic conditions have encouraged the rise of such phenomena as juvenile delinquency and prostitution. As a natural consequence, a considerable number of young people and children - ranging in age from 8 to perhaps 25 or more - live in the street. To survive, many start to work at a very early age, become prostitutes or serve as cheap labour in various specialized enterprises. In many instances, they play a significant role in the informal sector.

PROGRAMME COOPERATION, 1989-1992

10. The cooperation programme for the period 1989-1992 was aimed at reducing infant and maternal mortality and morbidity within the overall context of cooperation with the Government, taking account also of bilateral and multilateral cooperation inputs. For strategic and financial reasons, the programme thus developed mainly around two central elements, both of them in the field of health: EPI and a water supply and sanitation programme. A project on maternal and child health (MCH)/family planning (FP), involving especially midwife training and support for MCH/FP activities in health centres, and a project on women, nutrition and development were also started on a relatively small scale. In addition, an iodine-deficiency prevention project and later an AIDS-control project were formulated, but only the AIDS-control project has actually begun to be put into effect.

Health

11. The primary aim of the health programme was, through the MCH/FP activities and the training and equipping of health personnel for MCH and midwife activities, to strengthen the capacity of the basic health structures and improve the quality of the services offered to the public. But, given the health programme's limited coverage, and as a way of increasing the impact of health programme activities it placed heavy emphasis on programmes supported by the United States Agency for International Development (USAID) that focused primarily on control of diarrhoeal diseases (CDD) and malaria control. A number of health professionals, doctors, nurses and nurses' aides were retrained, 100 midwives were trained and equipped, and MCH material was supplied to 50 health centres. Regional bases, set up to organize and sustain EPI activities, were enlisted to improve the supervision of health personnel and the collection of data

12. Conceived and put into effect at the national level and designed specifically for the Central African Republic, EPI is exemplary in terms of both vaccination coverage and social mobilization. From 1989 to 1990, the vaccination coverage rate for tuberculosis rose from 80 per cent to 90 per cent, for measles from 57 per cent to 82 per cent, for diphtheria,

pertussis and tetanus from 43 per cent to 82 per cent, and for poliomyelitis from 43 per cent to 82 per cent.

13. Such vaccination coverage rates required very large-scale mobilization of both the authorities and the public. The public acquired the habit of systematically having children immunized, but at the same time the demand for quality health services rose very sharply. The implementation of EPI thus made it possible to prepare for the start of a large country-wide primary health care (PHC) programme. With a view to eradicating poliomyelitis, an epidemiological surveillance system is gradually being put into place. The sheer size of the country and the low population density led the Government to apply fixed, advanced and mobile strategies. The advanced strategy made it possible to expand coverage rapidly, but because of the high cost of the mobile strategy, 9 teams have already been disbanded and 12 others will be in 1993. At the same time, new fixed centres have been equipped and their staff trained in order to ensure that the programme will be ongoing and to maintain and even increase some of the vaccines available in the overall context of the implementation of the Bamako Initiative/PHC programme. However, since the end of 1990, the level of vaccination coverage for one-year-olds has declined in real terms.

14. The remarkable success of EPI naturally calls for measures to be taken to make the programme an ongoing effort. With that in mind, an inventory of health infrastructures, initially planned by the World Bank for the entire country, is being taken in three prefectures where the Bamako Initiative/PHC activities are to begin. Drugs and equipment are available for 14 health centres and subcentres in the three prefectures to meet the needs for one year of over 80 per cent of a population of more than 400,000. French cooperation assistance is supplying the hospitals in the prefectures.

15. Several consciousness-raising seminars bringing together mayors, municipal councillors, non-governmental organizations, technical services and community leaders have been organized in the three prefectures and have made it possible to reach over 250 people. A study of household income was made with USAID assistance, and the preparation of the management tools for the programme - a flow chart, management training units, registers, forms - is under way. Arrangements have been made to train the management committees.

16. The iodine-deficiency project planned as part of the 1989-1992 cooperation programme was, to begin with, the subject of a national survey in 1991 to determine the extent of the phenomenon. It has been learned that 63 per cent of the population suffers from iodine deficiency, with all the attendant consequences, namely, relatively high rates of sterility and miscarriage and notably poor scholastic performance, to say nothing of the aesthetic problems created by goitre. A project has been drawn up aimed at eradicating the deficiencies in the next five years by following three strategies, namely, installing iodine diffusers in wells; regulating the kind of salt imported, which should as far as possible be iodized; and injecting the most far-flung populations with lipiodole as part of EPI activities.

17. Under the village water supply and sanitation programme, 520 iodine diffusers have been ordered for installation in wells. This programme will start in the Nana-Grébizi prefecture, and will cover virtually 100 per cent of the water needs of 80,000 people. French cooperation assistance will supply 320 diffusers and a urinalysis laboratory, and UNICEF will supply 200 diffusers.

Water supply and sanitation

18. The water supply and sanitation programme is the second major sector of the cooperation programme. Started in 1987, this programme today supplies more than 250,000 people with drinking water in the prefectures of Nana-Grébizi, Ouham and Ombella-Mpoko and in Birao in the northern area of the country. In addition to the education-for-health activities, over 1,000 latrines have been built. Also, in connection with each well, the local management committee not only collects 50,000 CFA francs to maintain the well, even before it has been put into place, but it starts market gardening with the surplus water, which enables the population to eat vegetables and also to sell some of them, thus adding appreciably to family incomes.

Women, nutrition and development

19. The project on women, nutrition and development, planned earlier but not drawn up, started rather late with activities focusing primarily on food security and nutrition education and monitoring. Through the MCH/FP centres, the community development leaders present in the villages identify the malnourished children and monitor the mothers. They organize and lead activities with women's groups. This project, which covers three sub-prefectures and the Bangui area, is today following up on 50 women's groups and supplying equipment and teaching material to the network of MCH/FP centres. A nutrition survey done in the three sub-prefectures indicates that the rate of advanced malnutrition is as high as 6 or 7 per cent and that 25 per cent of children under five suffer from protein and calorie malnutrition. Nutritional monitoring and nutrtition education of mothers has been initiated in all the MCH centres.

Lessons drawn

20. Universal child immunization was the centrepiece of earlier cooperation activities, and the experience acquired is very instructive. It has shown especially the country's capacity to mobilize itself for the health of its children, but also its capacity to set goals and achieve them. Indeed, this programme is further proof that activities undertaken by the public authorities and the local community can be complementary and produce tangible results. Despite political events, the economic crisis and the long strikes in the sectors of health, education and water supply and sanitation, the action taken at the decentralized level (the village) has been to a large extent responsible for its present success and has shown the village to be a decentralized unit for programme planning and implementation on a human scale. Among the lessons learned from the previous cooperation programme is

the fact that advocacy and social mobilization activities are essential ways of creating public awareness of the problems and needs of children and above all inspiring the people to take part in programmes that are in their interest.

21. The assessments done in the course of preparing the mid-term review highlighted the difficulty the Central African Republic has in mobilizing additional funds and the need to devise a specific fund-raising strategy for the new programme. In general, the assessment reports emphasized that programmes were not sufficiently integrated, complementary or coordinated.

22. The main challenge for the period 1993-1997 is to ensure that health services at the community level, in the villages to be more precise, maintain the rate of coverage achieved in the area of vaccination and extend it to other key sectors like water supply and sanitation, education and nutrition.

RECOMMENDED PROGRAMME COOPERATION, 1993-1997

General resources: $ 6 000 000
Supplementary funding: $12 500 000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	2 250	5 676	7 926
Water supply and sanitation	400	4 584	4 984
Education	540	-	540
Community development and children in especially difficult circumstances	100	2 240	2 340
Social mobilization	250	-	250
Planning, statistics/assessment and follow-up	610	-	610
Programme support	1 850	-	1 850
Total	6 000	12 500	18 500

a/ A breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

23. The aim of the 1993-1997 cooperation programme is to respond decisively to the priority needs of children and women, in the context of the Government's development efforts. The cooperation programme is thus a component of the national plan of action and the national development plan, whose objectives as defined are consonant with the World Summit for Children in the areas of health, nutrition, education, water supply and sanitation, children in especially difficult circumstances, and the advancement of women. Furthermore, given the specific context in which the programme is to be implemented, its basic direction will be to reinforce community leadership and organization of the population for greater participation through greater responsibility, and to take an integrated approach to development problems through micro-planning.

24. The cooperation programme was drawn up after a review of the situation of children and women and of the preceding 1989-1992 cooperation programme. While engaging in low-cost activities, the programme must attend to the priorities set by the Government in the areas affecting children and women. Its objectives and strategies are likewise linked to those of the ongoing 1989-1992 programme, and it has been coordinated with programmes that are part of other bilateral, multilateral and non-governmental organization cooperation. This new programme largely reflects the overall priorities of UNICEF and in particular its strategies for children for the 1990s. The programme endeavours to make optimal use of the somewhat limited resources available to UNICEF.

Programme aims, objectives and strategies

25. The overall aim of the 1993-1997 cooperation programme is to improve the situation of children and women by putting into effect a set of programmes that have been coordinated for a synergistic effect, with a view to reducing child and maternal morbidity and mortality, favouring the utmost physical and intellectual development of the young child, and encouraging women to contribute decisively to the country's development. By assisting the Government to devise and pursue appropriate policies and approaches suited to the specific context of the country, involving a mobilization of grass-roots communities and villages as well as regional technical services, administrative district chiefs and local elected officials, the cooperation programme must ensure the full development of children, especially the development of their human potential and respect for their rights. It will help, specifically, to reduce IMR from 106 to 80 per 1,000 live births and U5MR from 180 to 140 per 1,000 live births. It will also help to reduce MMR from 600 to 400 per 100,000 live births. As regards the programme's quantified objectives, however, the figures will always be simply indicative. The reduction of mortality rates, while still one of the essential goals of the programme, must here be interpreted more as a focal point for efforts than as an absolute quantitative objective. These remarks naturally imply that it will be necessary to set up a system for collecting and analysing basic data.

26. In order to meet the immediate needs of the vulnerable groups and to attack the structural causes of their vulnerability, the new cooperation

programme will take several approaches. First, the Bamako Initiative/PHC programme will be set up in the seven most populated prefectures in the country, encompassing 51 per cent of the total population. In this connection, EPI, which offers national coverage, will be fully integrated in these areas and will naturally continue to be carried out in the rest of the country as in the past. The other projects under the health programme, namely, the AIDS-control project, the iodine-deficiency project, and the projects on community development and social mobilization, development of human resources, and national capacity-building, will also be put into effect in the seven prefectures. On the other hand, the water supply and sanitation project, because of the high cost of wells, will cover the three prefectures of Ouham, Nana-Mambéré and Mambéré-Kadéi.

27. The new cooperation programme is in itself a form of national capacity-building. In terms of content, objectives and approaches, the aim of the options chosen is to increase the institutional capacity of the country, in particular the villages and the prefectural technical services, and also to change the nature of the relationship between the population and the administrative authorities, especially the trusteeship they exercise over the local communities. The aim is likewise to increase the human resources in the areas of programme planning, follow-up and evaluation. With regard to the formulation of policies on behalf of children, the elaboration of the national action programme will have provided an opportunity first of all for bringing the partners together with the Ministry of Planning, and then for establishing an interministerial committee responsible for devising, elaborating, following up and evaluating development programmes in the social sector.

28. It goes without saying that the cooperation programme seeks to break new ground, and thus proposes objectives and strategies for sustainable and self-sustaining development. The selection of the village as the target point is not accidental. This choice, which has several advantages, was made after much thought and after discussions with the national authorities and research based on specific experience. The village is a legal person under public law and has the kind of financial independence that allows it to prepare programmes and fund them. Moreover, even if its structure is not very operational and its management and functioning need improvement, the village offers an exceptional framework within which development activities in all spheres can take place, resources can be generated and innovations can be made in the field of development.

Health

29. The health programme is made up of four projects whose objective is to significantly reduce disease and mortality rates among women and children by 1997. Faced with rising financial difficulties, the authorities have adopted a health-care strategy based on decentralization and community participation in compliance with the Bamako Initiative. The geographical and operational scope of the PHC project will be enhanced and expanded on the basis of prior experience. From now through the end of 1997, more than 50 per cent of the total national population will benefit from this project, under which the

following will be provided: prenatal and postnatal care, immunization, control of diarrhoeal diseases, the treatment of malaria and ARIs, as well as basic health care, in combination with projects dealing with nutrition, education, water purification and the environment. This programme will also strengthen institutional structures through community participation. UNICEF will continue to support training for community management committees, a first step towards effective community participation.

30. The objective of EPI is to expand immunization coverage for one-year-olds to 80 per cent and tetanus immunization for women of childbearing age to 90 per cent, and to maintain those levels. This project will thus have a direct impact upon the eradication of poliomyelitis and the elimination of neonatal tetanus. EPI will be gradually integrated into PHC in the seven prefectures covered by the PHC/Bamako Initiative Project.

31. An AIDS project of national scope will provide information, education and communication (IEC) in schools and universities. Though conceived as a separate project, its activities will be closely linked to PHC. In addition to IEC activities in schools and universities, its target will be the control of STDs in health centres within those areas covered by the PHC project. A systematic search for partners will be conducted in order to expand the programme throughout the country.

32. The prevalence of endemic goitre in the Central African Republic (62 per cent of the population from age 8 to 18) calls for a multisectoral strategy, involving health, agriculture and rural development, trade, water supply and so forth. The objective will be to inform the general population of the causes and consequences of iodine deficiency disorder (IDD) and to eliminate diseases stemming from iodine deficiency by 1996. This project will include an important IEC component. Its approach to IDD will be treatment by administering dietary supplements, and prevention by enriching and diversifying the diet, and by iodizing drinking water. This multisectoral strategy will be implemented through already existing programmes (EPI, village water supply, health education), which will be expanded for this purpose.

Water and sanitation

33. The water and sanitation programme consists of a village water project with a strong sanitation and health education component. The programme goal for 1993-1997, which is to sink 600 wells, will assist the Government in providing drinking water to 350,000 people. The sanitation and health education component is designed to have a direct impact on water-borne diseases. In accordance with Year 2000 goals, this component conforms to the long-term goals of the national programme, with emphasis upon the two following points: the reduction of infant mortality and the treatment of IDD. These goals will be achieved through the installation of iodine diffusers with the capacity to provide for between 400 and 500 people per well. The project is also designed to increase access to waste disposal systems by 80 per cent and to develop market gardening.

Education

34. This programme, which represents a new area of activity for UNICEF and the Central African Republic, will make use of a progressive strategy designed to strengthen State participation in the educational sphere. In conjunction with other agencies in the United Nations system, the principal NGOs and the World Bank, the first phase of the education programme will provide support to the Government for research and analysis aimed at a total overhaul of the educational system, comprising three parts: nursery-school education, basic education, and non-formal education. In the context of the second phase and of the next five-year plan, the Government has set the following goals for basic education: improving the quality of basic instruction; reducing regional differences in school courses and literacy; developing pre-school instruction throughout the nation; increasing the attendance rate for all children of school age, with emphasis on children from rural areas and especially girls; reducing the overall illiteracy rate, especially among women in rural areas; improving living conditions, through education, especially for women (reducing MMR, improving productivity, etc.) Since studies and analyses are presently under way, it is difficult to quantify the objectives, although they fall within the framework of those set by the World Conference on Education for All.

Community development and children in especially difficult circumstances

35. Community development is a horizontal programme which precedes and accompanies all other programmes, in terms of both providing leadership to and organizing grass-roots communities. Thus in the seven prefectures covered by the PHC/Bamako Initiative programme and in the 42 villages where micro-planning will be used, leadership and grass-roots organizing will lay the basic groundwork for other programmes. In addition to providing direct support for other programmes, this programme will improve social and economic conditions by raising awareness in the community of both its problems and its capacity to resolve them, and by developing appropriate technologies. In order to promote community participation in the funding of the PHC/Bamako Initiative programme and to set up an educational system which is better adapted to the requirements of development, sustained leadership, consciousness-raising and organizing will be used in all the areas in which the programme is implemented. The programme will provide training and such administrative and technical support as is necessary to enable people to identify their needs, to set up basic structures by means of micro-planning and to manage these structures using the funding methods set forth in the Bamako Initiative. It also proposes to help these communities to achieve lasting results, by setting up economic structures based on production, savings, trade, etc., so that they can generate their own income, which will in turn permit them to assume responsibility for social activities (health, education, culture).

36. A rapid survey of children in especially difficult circumstances, in the Central African Republic classified them in four groups: street children, disabled children, AIDS orphans, and children who work. Owing to the

precarious living conditions of most of the population, it is difficult to focus specifically on any one of these categories within the framework of the present programme. Given the limited resources of the programme, and pending a closer analysis, UNICEF has asked the NGOs working in this sector to create facilities for education, information and literacy for children. Three facilities will be established in the city of Bangui, whose purpose will be to help children to become reunited with their families, to receive care and to follow instruction in preparation for learning a trade. To improve their skills, sports activities are also envisaged.

Social mobilization and advocacy

37. The social mobilization programme will build on earlier experience with forging alliances, institutional capacity-building and intensified relations with all the various means and methods of communication, particularly traditional channels and direct information chains. It will comprise a national advocacy project and an information, education and communication (IEC) project. The aim of the advocacy project will be to heighten awareness of and popularize the national plan of action, the Convention on the Rights of the Child and the advancement of the status of women and to provide relevant information and training. UNICEF will also continue to promote the development of an advocacy strategy which includes using the opportunities provided by the mass media and formal and informal communication channels and lobbying high-level decision makers who can influence government structures, special interest groups, technicians and field agents.

38. The IEC project supports, in the health field, the implementation of PHC/Bamako Initiative, the EPI and the control of IDD; in the education field, schooling for girls, functional literacy (especially for women) and the promotion of school parent associations; and the water iodization and nutrition programme and the participation of community leaders in campaigns for access to drinking water. It also seeks to build institutional capacity in the IEC areas by markedly supporting the coordination and planning of all social mobilization activities aimed at benefiting maternal and child health, as well as management, training and material production, with a view to achieving the objectives of the national plan of action. It will assist the census and help to coordinate the use of mobilization mechanisms: networks of leaders from both the Government and the independent sector, the mass media, and technicians in the fields of health, education, water and sanitation. UNICEF will endorse a coherent approach that creates the conditions conducive to the behaviour change needed in order to accomplish the goals of the sectoral programmes between now and 1997.

Planning, monitoring and evaluation

39. In order to encourage the population to participate in implementing the programme and to have a sense of responsibility, micro-planning has been retained as a strategy. In terms of the country's administrative structures, this entails using the village to plan activities for the programme to promote child survival, protection and development with town councillors backed by a

national team, the administrative authorities and technical services. Initially, the process will entail studying the situation and identifying needs, followed by an analysis of the available human, financial and material resources. Finally, the activities pinpointed as priorities will be planned and implemented according to strategies determined by the people themselves.

40. Such an approach requires the introduction of a stringent system for monitoring and evaluating implementation of the programme. Accordingly, two main focal points of monitoring and evaluation have been singled out in the programme: in the context of national capacity-building, the introduction, in conjunction with the University, of a set of indicators for each individual sector and activity, and in the context of the social development unit at the Ministry of Planning, the introduction of a database covering all sectors. An appraisal is, of course, planned as soon as the programmes have been introduced, and periodic evaluations will be made in order to ensure that essential adjustments are made on a regular basis. Implementation of the programme will be evaluated in early 1995, prior to the mid-term review due to take place later that year. Specific evaluations of the programmes and projects financed under supplementary funding will also be made.

Coordination with other agencies

41. From the outset, the United Nations Development Fund, the World Health Organization, the United Nations Population Fund, the Food and Agriculture Organization of the United Nations, the World Food Programme and the World Bank have been involved in the programming process. They took part in the preparatory work, received and commented on the documentation prepared and put forward suggestions wherever feasible, particularly with regard to micro-planning at the village level, which stimulated particular interest owing to the potential for cooperation thus offered. Bilateral cooperation efforts, specifically between France and USAID, will continue under this new programme in the fields of primary health care and water. Non-governmental organizations will be routinely involved in implementing the programme.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Central African Republic	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	180	(1991)	Very high U5MR
Infant mortality rate	106	(1991)	Very high IMR
GNP per capita $	390	(1991)	Low GNP
Total population	3.1 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	80	104	135	138
Infant deaths (under 1)	(Thousands)	11	12	14	15
Under-five deaths	(Thousands)	19	21	24	25
Under-five mortality rate (per 1,000 live births)		240	202	182	180
Infant mortality rate (under 1) (per 1,000 live births)		140	119	107	106

		About 1980	Most recent
Underweight children (under 5) (% weight for age)	Moderate & severe	..	..
	Severe	..	..
Babies with low birth weight (%, 1973/1987)		23	15
% of primary school children reaching final grade, 1980/1987)		53	17

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%)		.. /../ ..	.. / .. / ..
Prevalence of wasting (%)		..	..
Prevalence of stunting (%)		..	..
Daily per capita calorie supply (% of requirements, 1979-81/1988-90)		94	82
Food production per capita index (Index 1979-1981=100, 1991)		..	93
Household expenditure (% of total income)	All food/cereals		.. / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1991)			24
Access to health services	Total	..	45
(% of population, 1985)	Urban/rural	.. / ..	.. / ..
Access to safe water	Total	16	26
(% of population, 1975/1990)	Urban/rural	.. / ..	32 / 21
Access to adequate sanitation	Total	..	..
(% of population, 1990)	Urban/rural	.. / ..	.. / 48
Births attended by trained personnel (%, 1988)		..	66
Maternal mortality rate (per 100,000 live births, 1983)		..	600

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	26	53	96	79
	DPT	12	24	82	46
	Polio	12	24	82	45
	Measles	16	30	82	46
Pregnant women (%) immunized against:	Tetanus	13	20	87	50

TABLE 1 (continued)

Central African Republic

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net)	Total	71 / 57	67 / 55
(%, 1980/1989)	Male	93 / 73	83 / 66
	Female	51 / 42	51 / 43
Secondary enrolment ratio (gross/net)	Total	14 / ..	11 / ..
(%, 1980/1989)	Male	21 / ..	17 / ..
	Female	7 / ..	6 / ..
Adult literacy rate, 15 years & older	Total	16	38
(%, 1980/1989)	Male/female	26 / 6	52 / 25
Radio/television sets (per 1,000 population, 1980/1990)		52 / 0	66 / 4

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Thousands)	1849	2313	3008	3090	3862
Population aged 0-15 years	(Thousands)	786	1019	1395	1440	1829
Population aged 0-4 years	(Thousands)	297	399	545	560	671
Urban population (% of total)		30	38	47	48	55
Life expectancy at birth	Total	42	45	47	47	46
(years)	Male	40	43	45	45	44
	Female	45	48	50	50	48
Total fertility rate		5.7	6.0	6.2	6.2	5.6
Crude birth rate (per 1,000 population)		43	45	45	44	42
Crude death rate (per 1,000 population)		23	20	18	18	18

		About 1980	Most recent
Contraceptive prevalence rate (%)		..	..
Population annual growth rate	Total	1.8	2.6
(%, 1965-1980/1980-1991)	Urban	4.8	4.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1991)		0.8	-1.5
Inflation rate (%, 1965-1980/1980-1990)		9	5
Population in absolute poverty (%, 1977)	Urban/rural	.. / ..	.. / 91
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure	Health/education	.. / ..	.. / ..
(% of total expenditure)	Defence	..	..
Household expenditure (% of total income)	Health/education	.. / ..	.. / ..
Official development assistance:	$US millions	111	225
(1980/1991)	As % of GNP	16	18
Debt service (% of goods and services exports, 1980/1990)		0	6

* UNICEF Field office source.
** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1989-1992 a/

COUNTRY: CENTRAL AFRICAN REPUBLIC
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $3,463,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SP		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	1752	576	158	34	548	384	648	364	3104	1035	1358	3140	4462	4175
Household food security and nutrition	128	169	18	6	155	2	156	29	455	144	206	546	661	690
Water supply and sanitation	430	325			396	192	236	53	1062	150	570	2352	1632	2502
Community organization and development	612	21	10		373		5		1000	414	21	814	1021	1228
Social mobilization and advocacy	35	131	15	88	23	48	50	208	123	108	475		598	108
Planning and social statistics	163		31		158		404		756	408			756	408
Programme support	137		4		639		267	5	1047	1204	5		1052	1204
GRAND TOTAL	3257	1222	234	128	2292	626	1764	659	7547	3463	2635	6852	10182	10315

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Includes additional general resources allocation for unfunded supplementary funding programmes.

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: CENTRAL AFRICAN REPUBLIC Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	450	450	450	450	450	2250
	FSF	178					178
	NSF	1138	1088	1150	1150	1150	5676
Water supply and sanitation	GR	100	50	100	100	50	400
	FSF	246					246
	NSF	902	942	980	880	880	4584
Education	GR	50	150	100	100	140	540
Community organization and development	GR	50	10	10	10	20	100
	FSF	105					105
	NSF	460	470	370	470	470	2240
Social mobilization and advocacy	GR	50	50	50	50	50	250
Planning and social statistics	GR	130	120	120	120	120	610
Programme support	GR	370	370	370	370	370	1850
TOTAL	GR	1200	1200	1200	1200	1200	6000
	FSF	529					529
	NSF	2500	2500	2500	2500	2500	12500
GRAND TOTAL		4229	3700	3700	3700	3700	19029

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.

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TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

CENTRAL AFRICAN REPUBLIC

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1993-1997 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
	GR	FSF	NSF	TOTAL	D2/L.1	D1/L.4	P/L.5	P/L.4	P/L.3	P/L.2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES										d/							
Health	2250			2250													
Water supply and sanitation	400			400						1	1			1	125		125
Education e/	540			540													
Community organization and development	100			100									1	1		141	141
Social mobilization and advocacy	250			250						1	1			1	125		125
Planning and social statistics	610			610								1	1	2		493	493
Programme support	1850			1850					1		1		7	8	585	987	1572
TOTAL GR	6000			6000					1	2	3	1	9	13	835	1621	2456
SUPPLEMENTARY FUNDING																	
Health		178	5676	5854				1	1		2		1	3	1230	141	1371
Water supply and sanitation		246	4584	4830				1	1	2	4		2	6	1890	282	2172
Education												1		1		352	352
Community organization and development		105	2240	2345					1		1		1	2	585	141	726
Programme support										1	1			1	125		125
TOTAL SF		529	12500	13029				2	3	3	8	1	4	13	3830	916	4746
TOTAL GR & SF				19029				2	4	5	11	2	13	26	4665	2537	7202
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994-1995)	Operating costs			1448													
	Staffing b/						1	1	1		3	1	7	11	913	859	1772
GRAND TOTAL (GR + SF + ADM)							1	3	5	5	14	3	20	37			
	Number of posts and staff costs:																
	- At the beginning of previous programme (1989)										d/ 14	1	18	33	N/A	N/A	N/A
	- At the beginning of proposed programme (1993)										d/ 14	3	20	37	N/A	N/A	N/A
	- At the end of proposed programme (1997) (Indicative										d/ 14	4	20	38	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

d/ Includes four United Nations volunteers.

e/ Under the supervision of the planning officer.

Abbreviations: GR = general resources, FSF = funded supplementary funding, NSF = new supplementary funding, SF = supplementary funding, IP = International Professional, NP = National Professional, GS = General Service, ADM = administrative.

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UNITED NATIONS CHILDREN'S FUND
Programme Committee
1993 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Mali

The Executive Director recommends that the Executive Board approve an amount of $20,625,000 from general resources, subject to the availability of funds, and an amount of $22,129,000 in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme of Mali for the period 1993-1997.

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* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/PL.2 and Add.1).

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THE SITUATION OF CHILDREN AND WOMEN

1. With a per capita income of US$ 270, Mali is among the 20 poorest countries in the world and its agriculture-based economy renders it very vulnerable to the vagaries of climate. The repeated droughts, which have been particularly severe in the northern regions, and environmental degradation have adversely affected the living conditions of children and women, resulting in food shortages, impoverishment of households, an increasing number of households headed by women as a result of the exodus of husbands in search of employment, an increase in child labour, and rampant urbanization. In addition, the workload of women and children has been further increased by the scarcity of firewood and the drying up of water points.

2. The infant mortality rate (IMR) is estimated at 108 per 1,000 live births and the child mortality rate at 225 per 1,000 live births. Almost 1 in 5, or approximately 85,000, children under the age of five die each year. Approximately 1,000 deliveries per 100,000 births result in the death of the mother. Diarrhoea, malaria and acute respiratory infections (ARI), aggravated by nutritional problems, are the three main causes of child mortality and alone account for more than 40 per cent of the deaths. Next come tetanus and measles. The shortage of basic services (health, education, drinking water, sanitation), the lack of food security and the low income of households largely account for the persistence of these high rates.

3. As elsewhere, acquired immune deficiency syndrome (AIDS) is spreading rapidly. Among high-risk groups, the rate had already reached 1 in 4 in 1987, and it is currently estimated at 60 per cent. In certain African countries, it is estimated that AIDS could bring about a 50 per cent increase in infant mortality between now and the end of the decade. Given that its prevalence is already very high in several neighbouring countries, Mali will certainly be increasingly affected by this problem.

4. Malnutrition is widespread and it is estimated that one third of children under 15 years of age are affected. Severe malnutrition is more common among children between 12 and 23 months (11 per cent). The highest rate of chronic malnutrition is encountered in the regions of Timbuktu, Gao, Kidal and Mopti (31 per cent). For the country as a whole, this rate is as high as 27 per cent in rural areas and remains high in urban areas (20 per cent). Deficiency diseases (diseases due to iodine deficiency, vitamin A deficiency and iron deficiency anaemia) are assuming disturbing proportions, but the incidence varies greatly from one area to another.

5. The literacy rate is 18 per cent. The rate for women as a whole is 11 per cent, falling as low as 5 per cent for women and girls in rural areas.

6. Only 40 per cent of the population of Mali lives within 15 kilometres of a health centre. It is therefore not surprising that fewer than one in four children below the age of one are fully vaccinated. For the same reason, only 15 per cent of pregnant women in Mali make at least one visit to a prenatal

clinic. Deliveries are attended by midwives in 16 per cent of cases and the same low rate is reflected in anti-tetanus coverage of women of child-bearing age, which is around 10 per cent for the country as a whole. Family planning activities reach only one in a hundred girls and women of child-bearing age and the monitoring of the growth of children under the age of four covers less than 1 per cent. Household budgets have to cover almost 60 per cent of the recurrent health-service costs, the remaining 40 per cent being covered by the State budget and, in particular, by donors.

7. With regard to water and sanitation, the average rate of access to water country-wide is 48 per cent. This figure conceals marked disparities between the regions (between 4 and 60 per cent), those in the north, where the terrain is much more difficult, being by far the worst served. It is estimated that the overall rate of access to sanitation facilities is approximately 15 per cent. Much remains to be done in improving the storage and utilization of water.

8. The primary school attendance rate is 28 per cent of children aged between 7 and 12 years of age, boys outnumbering girls nearly two to one. The figures show considerable differences between, on the one hand, the overall school attendance rate - which is 89 per cent in the Bamako district as against 19 per cent in the Kayes region - and, on the other, the school attendance rate of girls - which is 79 per cent in Bamako, as against 12 per cent in Mopti. Generally speaking, these are disparities within a single region, depending on whether an area is rural or urban. The reasons put forward for the low enrolment rates are the traditional ones of the irrelevance of the school curricula for rural areas and socio-cultural factors. It is these latter, inter alia, which militate against the school attendance of girls.

9. The position of women is largely determined by their excessive workload (household and agricultural duties), multiple pregnancies and traditional status. The productivity of women remains low as a result of the lack of training and access to credit, and this, in turn, reinforces their traditional status.

10. There are considerable regional disparities in terms of the availability of basic services, which are more thinly spread in the Sahelian zone. The low level of development of the country's resources and the socio-cultural constraints constitute additional obstacles to the solution of problems affecting children and women.

11. In a context of structural adjustment, the shortage of these basic services cannot be solved by the State alone. The restructuring of the public service and the privatization of public enterprises directly affect these services, even though it often happens that the enterprises are taken over by the communities. At the socio-political level, the aspiration of the people for a pluralistic democratic system and the deterioration of living conditions gave rise in March 1991 to a popular uprising and to the adoption of a new Constitution, which, following the election of a multi-party Government,

institutionalized the decentralization and devolution of the country's bureaucracy. Thus, the gradual disengagement of the State will be counterbalanced by the increased involvement of civilian society in the administration of its own welfare.

12. The Government of Mali was a co-President of the World Summit for Children and has ratified the Convention on the Rights of the Child. A national plan of action (NPA) for the survival, protection and development of children was prepared and adopted by the Council of Ministers of the interim Government in October 1991.

Primary objectives of the national plan of action

		1990	2000
1.	IMR (per 1,000 live births)	108	72
	U5MR (per 1,000 live births)	225	120
2.	MMR (per 100,000 live births)	1 000	500
3.	Moderate and severe malnutrition in children under 5 (per cent) (underweight)	33	22
4.	Access to safe drinking water (per cent)	48	72
5.	Access to sanitary means of excreta disposal (per cent)	15	30
6.	Basic education		
	Primary enrolment ratio (per cent)	23	46
	Percentage of children enrolled in the first year who complete the primary level	15	30
7.	Adult literacy rate (per cent)	19	50

PROGRAMME COOPERATION, 1988-1993

13. The elaboration of the cooperation programme for 1988-1993 drew heavily on the experience of the emergency assistance operations. The strategies adopted underscored the importance of sustained activities. The programme was executed by a set of projects managed through public and community agencies at the central, regional, district (cercle) and subdistrict (arrondissement) levels.

14. Health, the main programme area, comprised four components: the expanded programme on immunization (EPI), the enhancement of maternal and child health

services (MCH), the diarrhoeal diseases control (CDD) programme and decentralized health programming in the Djenné district. The first three components were intended to provide support for centrally-managed government departments. The experience acquired at Djenné was used to test the health planning and decentralized management model patterned after the Bamako Initiative.

15. Programming in the Djenné district was based on a health development plan for Djenné which integrated all social and health activities with budgeting of investment and operating costs. A new system of management was set up to permit the health centres to finance their activities partly from village financial contributions and partly from State subsidies. A system of charges for the services provided was introduced. The availability of essential drugs and an improvement in the quality of services led to a significant increase in the number of people using the health centres. The concept of cost recovery was found to be both feasible and acceptable.

16. On the basis of experiences such as that at Djenné, the Government has adopted a new health policy based on the integration of the different health services, hitherto too centralized. This policy envisages the establishment of community health centres which are fully funded by the communities but receive technical support from the health services. From 1990 on, UNICEF has reoriented its activities in line with this new policy and assigned primary health care (PHC) advisers to five regions. The rural health/population/water supply project was initiated with joint technical assistance from the World Bank, UNICEF, the United Nations Fund for Population Activities (UNFPA), the United States Agency for International Development (USAID), the European Development Fund (EDF), the French Fund for Aid and Cooperation (FAC) and the German Agency for Technical Cooperation (GTZ).

17. The expanded programme on immunization (EPI) was initiated in Mali at the end of 1986. There were obvious problems in sustaining such a programme in a country with a very poor infrastructure. The objective of attaining nationwide coverage as quickly as possible had resulted in a programme characterized by centralized management which made it more difficult to sustain. Moreover, it was realized that coverage could not be expanded any further. The decentralization of management initiated in 1991 resulted in substantial savings in operating costs. The local development committees took over the funding of certain categories of health personnel in order to increase the rate of immunization. That development helped to consolidate and expand measles immunization coverage from 3 per cent in 1987 to 39 per cent in 1991.

18. The reinforcement of MCH services was aimed at expanding coverage and improving the quality of services provided. To that end, some reorganization took place, mainly at the level of the district health centres. On the other hand, very few health centres at the subdistrict level were included in this exercise and this limited its impact. The new health policy placed the programme in a wider framework in order to create conditions propitious to the implementation of its activities.

19. The CDD programme established a unit for the production of packets of oral rehydration salts (ORS) of satisfactory quality. A study carried out in 1992 has shown that there were more of these packets available in regions where an essential drugs and decentralized planning policy had been introduced. Forty-one per cent of mothers use oral rehydration, 26 per cent in the form of ORS and 15 per cent in the form of a salt-sugar solution.

20. In the Sahelian zones where it was difficult for communities to have access to drinking water, UNICEF has improved the water purification system to make the water drinkable. Since 1989, 261 new wells have been sunk, 214 of them equipped with manual pumps purchased with contributions from the communities concerned. A private maintenance and repair network covering 1,300 pumps has been set up. The hygiene and sanitation component was initiated slowly, pending clarification of Government policy in this area. In 1991, in collaboration with the Government and the United Nations Development Programme (UNDP), UNICEF financed a study which proposed solutions to the problems of hygiene and sanitation in rural areas. The same year, UNICEF financed a national survey on dracontiasis. The disease was found to be endemic to 1,730 of the more than 8,000 villages covered by this survey. A nationwide programme to eradicate the disease was launched in late 1992.

21. In order to arrest the decline in the rates of primary school attendance, UNICEF, in collaboration with the Government, designed more appropriate curricula, especially in the area of health education. This latter project was tested in the Sahelian zone. The identification and implementation of an active goal-oriented teaching methodology, the design and production of teaching materials and the training of teachers are achievements which the Government integrated into the official teaching programmes in 1992.

22. The women's literacy project in the Sahelian zone was based on basic training in the national languages, reinforced by and integrated into community development projects. It has been noted that many children who are not enrolled in school attend the classes given at the project's literacy centres. This phenomenon is all the more remarkable in that the project was being carried out in areas where there was a very strong socio-cultural bias against the school enrolment of children. This experience has led the Government to develop a new programme, based on the women's literacy project, for these children who are not enrolled in school.

23. Family food security projects, which were basically the outcome of the emergency assistance programme, were executed in the Sahelian zone around Timbuktu, Bourem, Djenné and Ségou. In addition to improving the availability of food, these area-based projects also served as focal points for PHC, water supply and women's literacy projects. An ecological component was added in order to promote reforestation. A system managed directly by the communities was used to monitor nutrition among children. The Ségou project was, in effect, a joint nutrition support programme financed by the Italian Government through UNICEF and the World Health Organization (WHO). An external evaluation carried out in 1992 yielded positive results. In particular, the involvement of farmers in decision-making was singled out as a remarkable achievement.

24. The evolution of the situation in urban areas has marginalized an ever-growing segment of the population, the main victims being the street children and the women of the shanty towns. Studies have been undertaken with a view to identifying the problem more accurately. Collaboration has been developed with local non-governmental organizations (NGOs). Thus, the foundation has been laid for the development of a new programme for the period 1993-1997.

25. Communication and social mobilization efforts have focused on the development of a decentralized approach. The programme has devised responses to the immediate and specific needs of each region with regard to EPI, MCH, CDD, environmental sanitation and AIDS. The main obstacle has been the need to integrate the efforts of the various services. However, mobilization efforts with respect to EPI have enhanced awareness and understanding of the programme among virtually all segments of the population, including men. Since 1991, a pluralist private press and free radio stations have been established. The first steps have been taken towards establishing close collaboration with the mass media.

26. The programme on the monitoring of the situation of children and women has enabled the National Statistics and Data Processing Department to prepare a bulletin disseminating specific data on target groups. This exercise has shown the unreliability of the data generated by the technical departments. Thus, the formulation of the national plan of action (NPA) has once again emphasized the need to monitor the situation of children and women. An inter-ministerial committee has been established to devise machinery for the operational follow-up of indicators.

27. A number of points from the previous cooperation programme which were raised during the mid-term review and which resulted in adjustments to the programme in the course of its execution are worth mentioning. The experience acquired has highlighted the effectiveness of the decentralized planning of basic services and the importance of financial or organizational contributions from beneficiaries to the implementation of programmes. The need for greater operational integration among the various sectoral activities has been increasingly felt. Greater account should also be taken of structural adjustment in planning the contribution of the Government to the cooperation programme.

RECOMMENDED PROGRAMME COOPERATION 1993-1997

General resources: $20,625,000
Supplementary funds: $22,129,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	6 084	7 396	13 480
Water supply and environmental sanitation	1 855	4 447	6 302
Nutrition	2 680	4 286	6 966
Education	2 681	2 500	5 181
Early childhood development	1 030	1 500	2 530
Campaign against AIDS	500	500	1 000
Social mobilization and advocacy	1 030	1 500	2 530
Planning/social statistics	225	-	225
Programme support	4 540	-	4 540
Total	20 625	22 129	42 754

a/ The breakdown for estimated yearly expenditure is given in table 3.

b/ In addition, there are also funded supplementary funding projects in table 3.

28. The new cooperation programme is based, for the most part, on an analysis of the current situation of women and children, and takes into account the results and recommendations of the mid-term review conducted in March 1991. The new analysis was prepared by six inter-ministerial working groups. Their work culminated in a national workshop, held in January 1992, to which other United Nations agencies and various NGOs were invited. Since then, the Government and UNICEF have embarked on the formulation of a new cooperation programme. The first phase involved devising a strategy that would set forth the principal programme areas and sectoral approaches. The development of a

master plan and sectoral operational plans followed; this phase concluded with a meeting to review progress, held in July 1992. UNICEF and the Government have worked closely together throughout this process. The various meetings have encouraged exchanges of views between technical departments and other development partners. This series of meetings made it possible not only to better define coordination between the various agencies concerned, but also, and above all, to submit the proposals to the critical appraisal of all those involved.

29. The new cooperation programme takes into account the experience and evolution of the previous programme, during the course of which adjustments were made with a view to optimizing resources and programme impact and responding more effectively to the profound changes in the socio-political situation. These adjustments, which are features of the new programme, also correspond to the recommendations made in the UNICEF programme evaluation conducted jointly in Mali and five other countries by the Australian, Canadian, Danish and Swiss Governments. The evaluation team visited Mali during November 1991 and March 1992.

30. The analysis conducted in 1992 found that the health problems of children and women were the most severe, and ascribed them to dietary deficiencies and to the inadequacy of health structures. Other factors, such as malnutrition, poor hygiene and inadequate education, significantly contribute to these health problems.

31. The aim of the programme for 1993-1997 is to make decisive progress in the reduction of the infant and child mortality rates, so as to attain a rate of 72 and 120 per 1,000 live births, respectively, by the year 2000. It also aims to bring about a significant reduction in the maternal mortality rate (MMR). These objectives will be achieved through eight intersectoral programmes, the impact of which will be mutually reinforcing, and through the activities of other participants, such as United Nations agencies, donors and NGOs.

32. The priority to be assigned to the health sector will govern operational choices at the geographical level. In view of the importance of this sector, health activities will be carried out in all regions of the country, in collaboration with, and with complementary assistance from, the other partners - especially those involved in the rural health/population/water supply project - and several NGOs.

33. With a view to expanding health coverage (geographical and financial accessibility, availability of services), health services will be strengthened and developed within the framework of the Government's new sectoral policy, which aims to boost PHC. The pyramidal health model should evolve away from a hierarchical management concept and towards a more functional concept which would differentiate between levels of operation, support and orientation. The district, which represents the operational level, is the unit responsible for planning, budgeting, and managing health development.

34. Despite the limited purchasing power of these communities, their participation will be essential to the management of the basic health-care system and will thus help to ensure its durability, following the strategy set out in the Bamako Initiative, which advocates the partial funding of health services through contributions from the community towards the purchase of drugs.

35. UNICEF will provide high-level technical support to five regional directorates for the implementation of the programme, which will be co-funded by other donors. The aim of the programme is to create or rehabilitate 120 community health centres, revitalize 27 subdistrict health centres and upgrade the technical capacities of 21 district health centres. UNICEF will also provide material and technical assistance, in districts of this region and in districts of the Sikasso region, for the revitalization of 70 additional subdistrict health centres and the creation of 40 community health centres, and will take full responsibility for their funding. A minimum package of curative and preventive care and promotional material will be developed and established in all these health centres, where it will be available to the community. This minimum package will also include essential drugs.

36. The three northern regions not covered by the rural health/population/water supply project will be served by a project proposed by UNICEF and the European Development Fund (EDF), which will adopt a similar approach. Environmental conditions and the dispersal of population groups favour a strategy involving mobility and versatility to supplement the 30 subdistrict health centres to be revitalized.

37. With regard to family planning activities, the rural health/population/water supply project will expand the coverage throughout the country. In line with the new health policy, family planning activities form an integral part of the services offered at all health centres. This component will be supported by USAID.

38. Programmes under centralized management, in particular EPI and CDD, will be gradually integrated into the basic health services at the district, subdistrict and community levels through the minimum package. This development should ensure the continuity of the programme by lowering costs through a more rational use of resources, particularly logistic resources.

39. On the national level, strategies will be devised to reduce the incidence of diseases that are the most frequent causes of death among children and the high maternal mortality rate in Mali. These include strategies to combat malaria, ARI, sexually transmitted diseases (STD) and perinatal problems. Special attention will be paid to the health problems of women. All these activities will be integrated into the minimum package for marginal population groups.

40. The northern regions, where basic services are more limited, will continue to be the priority programme area for water, drainage and education programmes. In the same area, but on a more limited geographical scale,

nutrition and food security activities will serve as an instrument for the integration of all activities. Environmental degradation, the fragility of the economic fabric and the vulnerability of the population of those regions, which were accentuated by the droughts of the 1980s, were important considerations in this choice. These various activities should reinforce activities in the health sector and have a maximum impact on the welfare of women and children.

41. An improvement in conditions of hygiene and clean water supply are crucial factors in lowering the incidence of diseases which kill children. Furthermore, easy access to water supply reduces the workload of women. Better health can only be achieved through new attitudes, practices and knowledge with regard to waste disposal and general hygiene. Health education will thus be the main thrust of the programme. The eradication of dracontiasis will be the primary focus of health education in those areas where it is endemic, since it will illustrate to the population the decisive impact of good hygiene and proper sanitation.

42. Village water supply projects will advocate the use of sound and sustainable approaches within the reach of villagers in order to supply the drinking water needs of rural communities in the Sahelian zone. The supply of essential spare parts for manual pumps will be improved in order to allow UNICEF to disengage progressively. Execution will follow an integrated approach based on the maximum participation of the community, particularly of women, in the planning and implementation of activities, the operation and maintenance of installations and the monitoring and evaluation of their impact.

43. Formal primary schooling, which until now has been the keystone of the Government's strategy to raise the country's literacy level, still does not appear to meet the needs and desires of rural population groups, despite considerable investment by many partners. The enrolment rate in this sector has stagnated, and is even declining, because of such factors as the high birth rate. At the same time, enrolment in medersas (one of the forms of Arab-Islamic private education in Mali) is increasing; the total number of students now represents 20 per cent of the children enrolled in the first cycle of primary school. Primary schooling will, therefore, be strengthened through support to the medersas. The programme will aim at raising the level of teachers, adopting an improved and harmonized curriculum and reinforcing the teaching of French.

44. Non-formal education will be supported through basic education centres which will be accessible to children not enrolled in formal schools and to women between the ages of 16 and 45. These centres will offer a minimum level of basic training designed to prepare young people to enter an apprenticeship and to help adult beneficiaries to function in their environment as agents of development responsible for the health and social and economic welfare of their families and communities. Linkages will be defined between this type of education and formal public education. The project will support the training of leaders, the development of the school curriculum and the production of

teaching materials. Libraries and collections of audio materials will be established in order to provide the tools for continuing education.

45. A non-institutional approach, aimed at the family and the community, will be taken to the promotion, protection and development of the young child. The child as learner, the parents as educators, the family (siblings and grandparents) as an environment for life and learning, and the community as support to the family will be targeted. This concept will help young children to develop more fully: psycho-motor development, nutrition, health care, physical and emotional well-being, and more relationships and stimulation. The project will train and arouse the awareness of parents, educators and local leaders with regard to teaching approaches which promote the rapid awakening of the young child. The introduction of innovative and low-cost activities in community centres will be supported. During the initial phase, the activities will be carried out on a modest scale.

46. Malnutrition, which contributes significantly to infant mortality, is closely linked to the availability of food, the use of foods and the socio-economic situation of families, as well as to such equally important factors as the nutritional knowledge, attitudes and practices of mothers. In regions where the food supply is generally secure, malnutrition is, above all, a result of nutritional practices and the scant attention paid to the nutrition of children, pregnant women and nursing mothers. In the Sahelian zone, however, the basic problem is a lack of food and the means to buy it.

47. UNICEF intervention is proposed at both the central and the peripheral levels. At the central level, the programme will strengthen national capacities with regard to policy formulation and nutritional activities. The emphasis will be on the use of data on the nutritional situation of children and deficiencies in micro-nutrients. At the regional level, integrated community-based activities will be introduced, giving priority to women. Activities will centre on increasing and diversifying food production, health education, literacy, village water supply, and reducing women's working hours and enhancing their value.

48. In urban areas, the need for basic services exceeds the available means. The stagnation of such services in terms of coverage and capacity, as well as impoverishment and unemployment, have had marked negative effects on the living conditions of children and women. A category of marginalized children and women has emerged and its numbers are growing. It is proposed that activities under the programme will be carried out in peri-urban areas, particularly in the Bamako district and the town of Mopti. These activities will be directed towards women and children with a view to promoting and enhancing their current and future role as mothers and heads of families. The activities will be aimed at increasing their ability to meet their own needs and improving their educational and health situation. This should help their integration into society.

49. The prevention of AIDS, a disease which is spreading rapidly and which is always fatal, has become imperative. The strategy is based on a few

established facts. The transmission of the disease is promoted by migration between Mali and certain neighbouring countries where rates of infection are already high. The alarming increase of human immunodeficiency virus (HIV) infection among girls once they reach the 15-19 age group, in comparison with boys in the same age group, and the role of STD are other factors to be taken into account in combating AIDS.

50. UNICEF advocates support to the national programme to combat AIDS in two areas: changes in behaviour among youth in the 10-to-19 age group and the prevention and monitoring of STD. Other areas of the fight against AIDS will be covered by other donors such as UNDP, WHO, USAID, the Canadian International Development Agency and FAC.

51. The objectives of the World Summit for Children and the Convention on the Rights of the Child must be known and supported by decision-makers and the general public. Information on simple measures that can help to reduce infant, child and maternal mortality should be transmitted to communities. These two obligations are reflected in the new cooperation programme by a sectoral advocacy and communication programme.

52. Advocacy will, inter alia, focus on legislation affecting children and women, the National Plan of Action (NPA) and the baby-friendly hospital initiative.

53. Efforts in the communications area will involve improved transmittal of information within sectoral programmes for the benefit of recipients. In order to achieve this, activities relating to training in communications and the production, support and reinforcement of national capacities will be undertaken with a view to mobilizing the community. The promotion of specific aspects is essentially designed to bring about and consolidate a constructive attitude in general, and with regard to certain specific problems, in particular. Effective communications activities will be developed in order to bring about changes among individuals and households with a view to the better utilization and promotion of services.

54. The situation of children and women will be monitored through certain key indicators set forth at the World Summit for Children. The various sectoral programmes should use these indicators as guidelines in order to promote the attainment of the objectives that Mali has set for itself. It will thus be possible to measure the impact of the efforts undertaken. This monitoring will cover the entire national territory. Its principal focus will be the upgrading of regional offices, which until now have merely relayed data to the centre. Their upgrading will provide the services at the peripheral level with immediate access to data in order to monitor their own activities.

55. Since Mali is a country which receives sizeable contributions for development, coordination with other partners (national, international, bilateral and NGOs) in various fields will continue to be essential. Such cooperation will make it possible to maximize the impact of activities, on the one hand, and, on the other, to ensure that the territory is well covered.

56. The scope of the Government's commitment to the attainment of the objectives for the 1990s is reflected in the integration into the Mali-UNICEF cooperation programme and the sectoral programmes of the specific items related to monitoring and evaluation. These items constitute the pilot mechanism of the programmes/projects and specify the indicators to be selected, as well as the frequency and level of observation. Each cross-sectoral programme sets out a schedule for evaluating those aspects which are regarded as pertinent by two parties. The evaluations will permit the appraisal of the strategies, organization, use of material, equipment and funding, methods employed and results obtained in relation to the objectives set and the resources utilized. The results of these evaluations will assist in the preparation of the mid-term review and the evaluation of the cooperation programme. The latter is due to take place towards the end of th fourth year of implementation so that the results can be integrated into the next cooperation programme.

57. The effective integration of different activities, whether undertaken under the Mali-UNICEF cooperation programme or under other programmes, will be facilitated by the decentralized development institutions already in place: the regional and local development committees. These institutions favour local participation by community development technicians and "tons" (traditional village associations). The programme will be aimed particularly at women, not only as beneficiaries, but also as participants and managers. Their involvement will be the best guarantee of achieving the intended impact and sustained results.

58. For its part, UNICEF will manage the 1993-1997 cooperation programme through the Bamako office and four area offices in Gao, Timbuktu, Mopti and Ségou. The staff of the Bamako office is responsible for the central level, while the area offices are responsible for scheduling and monitoring the programmes from the UNICEF side at the regional and peripheral levels. These two components constitute the major support for the programmes. The link between the two levels is essential to ensure coherence between national policies and execution at the decentralized level. The area offices are managed by national professionals. They are already staffed by international Professionals and United Nations volunteers in the areas of health, nutrition and community development.

59. The number of staff at UNICEF's Mali office has, in short, been slightly reduced. It has therefore proved necessary to introduce significant changes regarding the assignment of staff to the various programmes and the allocation of tasks. The social mobilization and communication programme will receive staff reinforcements so that it will be able to respond to the new demands of the programme, resulting mainly from Mali's national plan of action (NPA). Five international posts (a mixture of United Nations professionals and volunteers) have been abolished in favour of national capacity-building.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Mali	(1991 and earlier years)		UNICEF country classification
Under-five mortality rate	225	(1991)	Very high U5MR
Infant mortality rate	108	(1991)	Very high IMR
GNP per capita	$ 280	(1991)	Low GNP
Total population	9.5 Million	(1991)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1991
Births	(Thousands)	283	352	472	487
Infant deaths (under 1)	(Thousands)	54	53	52	53
Under-five deaths	(Thousands)	124	118	110	111
Under-five mortality rate (per 1,000 live births)		380	310	230	225
Infant mortality rate (under 1) (per 1,000 live births)		190	150	110	108

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1987)	Moderate & severe	--	31 a/
	Severe	--	9 a/
Babies with low birth weight (%, 1979/1982-1985)		13	17
% of primary school children reaching final grade (1980/1988)		45	40

NUTRITION INDICATORS		About 1980	Most recent
Mothers breast-feeding at 3/6/12 months (%, 1980/1987)		96/../82	91 / 95 / 82
Prevalence of wasting (%, 1987)		26	16
Prevalence of stunting (%, 1987)		..	34 a/
Daily per capita calorie supply (% of requirements, 1988-1990)		..	96
Food production per capita index (Index 1979-1981=100, 1980/1991)		97	97
Household expenditure (% of total income, 1980-1985)	All food/cereals		57 / 22

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%)			..
Access to health services	Total	..	15
(% of population, 1985)	Urban/rural	.. / ..	.. / ..
Access to safe water	Total	6	41
(% of population, 1980/1990)	Urban/rural	37 / 0	53 / 38
Access to adequate sanitation	Total	..	19
(% of population, 1980/1985)	Urban/rural	79 / ..	90 / 3
Births attended by trained personnel (%, 1987)		..	32
Maternal mortality rate (per 100,000 live births, 1987)		..	2000

Immunization		1981	1985	1990	1991
One-year olds (%) immunized against:	Tuberculosis	19	13	82	68
	DPT	..	2	42	34
	Polio	..	2	42	34
	Measles	..	13	43	39
Pregnant women (%) immunized against:	Tetanus	1	..	31	9

TABLE 1 (continued)

Mali

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%,1980/1990)	Total	27 / 20	24 / 19
	Male	34 / ..	30 / 24
	Female	19 / ..	17 / 14
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	9 / ..	.. / ..
	Male	13 / ..	.. / ..
	Female	5 / ..	.. / ..
Adult literacy rate, 15 years & older (%, 1970/1990)	Total	8	32
	Male/female	11 / 4	41 / 24
Radio/television sets (per 1,000 population, 1980/1990)		15 / ..	43 / 1

DEMOGRAPHIC INDICATORS		1970	1980	1990	1991	2000**
Total population	(Millions)	5.5	6.9	9.2	9.5	13
Population aged 0-15 years	(Thousands)	2653	3400	4529	4695	6218
Population aged 0-4 years	(Thousands)	1033	1312	1804	1869	2358
Urban population (% of total)		14	17	19	25	30
Life expectancy at birth (years)	Total	38	41	45	45	49
	Male	36	40	43	44	47
	Female	39	43	47	47	51
Total fertility rate		7.1	7.1	7.1	7.1	6.4
Crude birth rate (per 1,000 population)		51	51	51	51	46
Crude death rate (per 1,000 population)		26	23	20	20	16

		About 1980	Most recent
Contraceptive prevalence rate (%, 1977/1987)		1	5
Population annual growth rate (%, 1965-1980/1980-1991)	Total	2.1	3.0
	Urban	4.9	5.6

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1967-1980/1980-1991)		2.1	-0.1
Inflation rate (%, 1967-1980/1980-1990)		..	3
Population in absolute poverty (%, 1975)	Urban/rural	27 / 48	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure	Health/education	.. / ..	4* / 17*
(% of total expenditure, 1987)	Defence	..	17*
Household expenditure	Health/education	1 / 2	4* / 7*
(% of total income, 1980-1985/1988-1989)			
Official development assistance:	$US millions	267	408
(1980/1991)	As % of GNP	22	17
Debt service (% of goods and services exports, 1980/1990		3	7

a/ Indicates data that differ from the standard definition, or refer to only part of a country.
* UNICEF field office source.
** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1988–1993 a/

COUNTRY: MALI
LATEST BOARD APPROVAL: 1988
GENERAL RESOURCES: $18,553,000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	3635	2069	209	125	1471	796	1814	1408	7129	6588	4398	3270	11527	9858
Household food security and nutrition	490	1015	36	37	681	1290	639	1298	1846	1385	3640	14048	5486	15433
Water supply and sanitation	2497	1703	16	106	73	865	812	1332	3398	3285	4006	8685	7404	11970
Education	608	22	144		22		328		1102	1427	22	2001	1124	3428
Community organization and development	1	60					31	41	32		101		133	
Women-centred programme	70		27	35			56		153	150	35	75	188	225
Planning and social statistics	768	9	158		3042		2165	6	6133	5718	15		6148	5718
Emergency	50	206						26	50		232	1679	282	1679
Freight	197	192							197		192		389	
GRAND TOTAL	8316	5276	590	303	5289	2951	5845	4111	20040 b/	18553	12641	29758 c/	32681	48311

GR = General resources.
FSF = Funded supplementary funding.
SF = Supplementary funding, funded and unfunded.

a/ Actual expenditure includes expenditure recorded as of 17 December 1992.

b/ Including allocations from global reserve funds for unfunded supplementary funding programme.

c/ Of this amount, $3,700,000 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1993 – 1997

(In thousands of United States dollars)

Country: MALI Period covered: 1993 – 1997	Funding status	1993	1994	1995	1996	1997	Total
Health	GR	1240	1193	1217	1217	1217	6084
	FSF	1854					1854
	NSF	952	2365	1508	1584	987	7396
Household food security and nutrition	GR	536	523	536	548	537	2680
	FSF	714					714
	NSF	286	1000	1000	1000	1000	4286
Water supply and sanitation	GR	371	371	371	371	371	1855
	FSF	303					303
	NSF	1006	1746	1039	509	147	4447
Education	GR	436	600	561	549	535	2681
	NSF	500	500	500	500	500	2500
Young child development	GR	206	206	206	206	206	1030
	NSF	300	300	300	300	300	1500
Aids programme	GR	127	73	100	100	100	500
	NSF	73	127	100	100	100	500
Social mobilization and advocacy	GR	256	206	181	181	206	1030
	NSF	300	300	300	300	300	1500
Planning and social statistics	GR	45	45	45	45	45	225
Programme support	GR	908	908	908	908	908	4540
	FSF	90					90
TOTAL	GR	4125	4125	4125	4125	4125	20625 a/
	FSF	2961					2961
	NSF	3417	6338	4747	4293	3334	22129
GRAND TOTAL		10503	10463	8872	8418	7459	45715

GR = General resources.
FSF = Funded supplementary funding.
NSF = New supplementary funding.

a/ Not including balances of additional general resources allocation $150,000 for education and $640,000 for water supply and sanitation.

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TABLE 4. LINKAGE OF PROGRAMME BUDGET AND STAFFING/STAFF COSTS

MALI

PROGRAMME SECTION/AREAS AND FUNDING SOURCES	PROGRAMME BUDGET 1993-1997 (In thousands of US dollars)				POSTS a/ and b/ EXISTING POSTS						SUBTOTAL			TOTAL POSTS	STAFF COSTS c/ (In thousands of US dollars)		
	GR	FSF	NSF	TOTAL	D2/L3	D1/L4	P/L5	P/L4	P/L3	P/L2	IP	NP	GS		IP	LOCAL	TOTAL
GENERAL RESOURCES																	
Health	6084			6084				4			4		5	9	2580	495	3075
Household food security and nutrition	2680			2680				1			1	1	1	3	645	424	1069
Water supply and sanitation	1855			1855													
Education	2681			2681					1		1		1	2	585	99	684
Young child development	1030			1030													
Aids programme	500			500								1		1		325	325
Advocacy and social mobilization	1030			1030									1	1		128	128
Planning and social statistics	225			225								1	1	2		424	424
Programme support	4540			4540								7	16	23		3859	3859
TOTAL GR	20625			20625				5	1		6	10	25	41	3810	5754	9564
SUPPLEMENTARY FUNDING																	
Health		1854	7396	9250				3			3	1	4	8	1935	751	2686
Household food security and nutrition		714	4286	5000					2		2		3	5	1170	297	1467
Water supply and sanitation		303	4447	4750				1			1	1	2	4	645	523	1168
Education			2500	2500													
Young child development			1500	1500													
Aids programme			500	500													
Advocacy and social mobilization			1500	1500													
Programme support		90		90													
TOTAL SF		2961	22129	25090				4	2		6	2	9	17	3750	1571	5321
TOTAL GR & SF				45715				9	3		12	12	34	58	7560	7325	14885
ADM. AND PROGRAMME SUPPORT BUDGET (Proposed 1994-1995)	Operating costs			883													
	Staffing b/					1	1	1			3	4	12	19	929	1201	2130
GRAND TOTAL (GR + SF + ADM)						1	1	10	3		15	16	46	77			
	Number of posts and staff costs:																
	- At the beginning of previous programme (1988)										15	11	31	57	N/A	N/A	N/A
	- At the beginning of proposed programme (1993)										15	16	46	77	N/A	N/A	N/A
	- At the end of proposed programme (1997) (Indicative only)										16	17	47	80	N/A	N/A	N/A

a/ Each post, regardless of its funding source, supports the country programme as a whole.

b/ The posts are effective as of 1 January 1994.

c/ Project posts are funded for five years and core posts are funded for two years.

Abbreviations: GR = general resources; FSF = funded supplementary funding; NSF = new supplementary funding; SF = supplementary funding; IP = International Professional; NP = National Professional; GS = General Service; ADM = administrative.